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ABSTRACT

By the Older Americans Amendments of 1975, the U.S. Commission on Civil Rights was directed to investigate unreasonable age discrimination in federally-assisted programs, report the findings and recommend statutory changes for administrative actions. Results of examinations of the literature, field studies and public hearings on the following programs are reported here: Community Health Centers, Food Stamps, Medicaid, Community Mental Health Centers, Vocational Rehabilitation, CETA, Titles I, II, and VI, Title XX Social Services of the Social Security Act, Legal Services, Adult Basic Education, and Vocational Education. (Author/BEF)

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The Age Discrimination Study

Part II

A REPORT
OF THE
UNITED STATES
COMMISSION
ON CIVIL RIGHTS

January 1979

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U.S. DEPARTMENT OF HEALTH,
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U.S. COMMISSION ON CIVIL RIGHTS

The U.S. Commission on Civil Rights is a temporary, independent, bipartisan agency established by Congress in 1957 and directed to:

- Investigate complaints alleging that citizens are being deprived of their right to vote by reason of their race, color, religion, sex, or national origin, or by reason of fraudulent practices;

- Study and collect information concerning legal developments constituting a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, or national origin, or in the administration of justice;

- Appraise Federal laws and policies with respect to the denial of equal protection of the laws because of race, color, religion, sex, or national origin, or in the administration of justice;

- Serve as a national clearinghouse for information in respect to denials of equal protection of the laws because of race, color, religion, sex, or national origin;

- Submit reports, findings, and recommendations to the President and the Congress.

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By the Older Americans Amendments of 1975, the U.S. Commission on Civil Rights was directed to: investigate unreasonable age discrimination in federally-assisted programs; report the findings

of the investigation to Congress, the President, and affected Federal agencies; recommend statutory changes or administrative actions based on its findings and general regulations for implementation of the Age Discrimination Act of 1975.

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Introduction

The U.S. Commission on Civil Rights released the report of its age discrimination study on January 10, 1978. The report set forth the Commission's findings and recommendations based on an 18-month study of 10 federally-assisted programs and selected aspects of the field of higher education. Since that time, the Commission has also published the transcripts and exhibits from the four public hearings held in San Francisco, California; Denver, Colorado; Miami, Florida; and Washington, D.C.

This volume is the final publication from the Commission's study of discrimination on the basis of age. It includes a description of the methodology that was employed to execute the study. Separate chapters describe each program examined by the Commission and summarize the record of information obtained through a literature search, data analysis, the field study, and the public hearings. Although the record taken in its entirety for all programs formed the basis for the Commission's findings and recommendations, it was believed that presenting the information on a program-by-program basis would prove more useful to those with particular interests. This volume should be read and considered in conjunction with the Commission's report of its findings and recommendations and the transcripts of hearings, since a concerted attempt was made to minimize redundancy.

Methodology

The Age Discrimination Act of 1975 was enacted into law on November 28, 1975, as part of the Older Americans Amendments (P.L. 94–135). The express purpose of the act is to prohibit unreasonable discrimination based on age in programs or activities receiving Federal financial assistance, including programs or activities receiving funds under the State and Local Fiscal Assistance Act of 1972. The act provides further that pursuant to regulations issued by the Secretary of Health, Education, and Welfare and the heads of certain other Federal departments and agencies, but no sooner than January 1, 1979:

> . . .no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance. . . .

The principal provision of the act which concerned the Commission on Civil Rights was that directing the Commission to conduct a study of unreasonable discrimination based on age in programs or activities receiving Federal financial assistance and to identify, with particularity, any such federally-assisted program or activity in which there is evidence of otherwise qualified persons on the basis of age being excluded from participation in, denied the benefits of, or otherwise subjected to discrimination under such program or activity. As part of its study, the Commission was required to hold public hearings on issues relating to age discrimination and particularly with respect to the issue of reasonableness.

The age discrimination study began in July 1976. After an exhaustive review of the act's legislative history, the Commission set out to accomplish the following:

- Formulate some preliminary concept or definition of age discrimination which could be used to measure program behavior.
- Determine whether and which individuals or groups of individuals are being discriminated against on the basis of age in federally-assisted programs.
- Locate the source of any discriminatory practice or outcome.
- Ascertain the reasons or justifications offered to explain the practices or outcomes.
- Judge the "reasonableness" of the justification.
- Determine whether alternative practices exist that might be available to the administrators involved.
- Assess the act against the findings and determine whether it would help solve the identified problems.
- Elicit the views of those administering federally-assisted programs, and recipients or their representatives, on the question of age discrimination.

- Produce a set of recommendations, including suggested general regulations, which could be put into place.

To meet these objectives, the Commission set four research tasks:

- Legal research and analysis
- Selection of Federal programs for examination and development of the study's conceptual framework
- Field study
- Public hearings

Legal Research and Analysis

The legal research and analysis effort underpinned the entire study and influenced execution of the other efforts.. It focused on several questions: (1) what theories and approaches in cases involving discrimination on the basis of factors such as race, sex, and national origin might be relevant for developing a concept of age discrimination; (2) what lines of inquiry do these theories imply for conducting the study; and (3) what specific legal issues arise from the act's provisions suggesting further legal analysis and other research and the development of recommendations and general regulations?

The Commission conducted an extensive review of the case law involving discrimination in violation of the Constitution and of the relevant statutory law, such as Titles VI and VII of the Civil Rights Act and the Age Discrimination in Employment Act. The implementing regulations for the statutes were also analyzed. In addition, the Commission analyzed the Age Discrimination Act focusing on its jurisdictional provisions, compliance machinery, and substantive provisions affecting any definition of age discrimination.[1]

Selection of Federal Programs and Development of Conceptual Framework

Two questions arose early in the study with regard to the selection of programs: (1) Should the study focus on and seek to determine the presence or absence of discrimination against one or more specific and narrowly defined age groups or across the entire age spectrum? and (2) what federally-assisted programs should be studied and on what basis should they be chosen?

On the first question, there was a strong case for limiting the study to an investigation of discrimination against older persons. Enactment of the Age Discrimination Act can be traced to a primary concern about discrimination against older persons and to a belief that older persons are not receiving a fair share of available services and benefits under many Federal programs. The legislative history of the act demonstrated a principal concern with discrimination against older persons: (a) The act is Title III of the Older Americans Amendments of 1975. (b) The act arose from House and Senate Committees that were considering legislation to extend and amend the Older Americans Act. (c) Virtually all of the examples of discrimination cited in the Committee reports and during floor debates in the House and the Senate concerned the prohibition related to older persons. Limiting the study to determining whether or not discrimination against older persons exists in federally-assisted programs and activities would have greatly simplified the research task. "Older persons" is an easily-understandable and observable category of program participants and beneficiaries.

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[1] Memoranda resulting from this analysis are located in the files of the Commission.

A case was also made, though, for assuming a broader perspective and not limiting the focus of study to a particular age group. The language of the statute neither states nor implies that either the study or the ultimate ban on age discrimination should concern itself only with older persons. The conference report that accompanied the act in no way suggests that either the study or the ban should be limited to one group.

The Commission concluded: (1) that it should make no assumptions that one or more age groups were being discriminated against; (2) that even if it looked at one age group, it would have to look at others to establish measures of comparative treatment; (3) that since the act protects persons of all ages, conclusions as to one age group would not be helpful as to others if different considerations caused discrimination among and between age groups; (4) that the research task in pursuing a broader perspective did not seem to be of any greater magnitude than pursuing a narrower approach. Therefore, the study was directed at identifying discrimination on the basis of age, whatever the age of the victim of discrimination.

With regard to the second question concerning program selection, the Commission was cognizant of the limited resources and time to conduct the study and was thus determined to select those approaches and specific topics for study that would best shed light on the significant issues and support that might apply to programs or practices not studied.

The Commission had concluded earlier that studying particular Federal programs was necessary to examine what aspects of a program resulted in age discrimination—from the Federal statutory and regulatory provisions, to administrators' actions, to the delivery of the intended benefits or services. Such an approach would permit a more precise identification of the cause or source of any age discrimination found. Resource and time constraints required choosing a limited number of Federal programs. However, there was concern that the programs selected represent as many as possible kinds of Federal programs that would be affected by the act to ensure that most of the issues related to age discrimination and the provisions of the act were raised.

Other considerations guiding the Commission's choice of Federal programs included the following:

1. that the programs are intended for the general population in need, regardless of age;

2. that they include those programs identified in the House and Senate hearings on the Age Discrimination Act as examples of age discrimination, indicating what generated the most concern;

3. that they provide coverage of a range of Federal agencies and functional areas such as health and education;

4. that they represent a range in size of intended benefits in terms of appropriations;

5. that the programs offer important benefits to their intended beneficiaries;

6. that they cover different types of grantees, for example, State governments and local, nonprofit, private organizations;

7. that they include programs representative of recent trends in Federal programming, for example, block grants;

8. that findings from the programs studied increase the likelihood of answering some of the questions raised by the act.

After weighing all of these considerations and the universe of federally-assisted programs, the Commission selected the following programs:

- Community Health Centers
- Food Stamps
- Medicaid
- Community Mental Health Centers
- Vocational Rehabilitation
- Comprehensive Employment and Training Act—Titles I, II, and VI
- Title XX Social Services of the Social Security Act
- Legal Services
- Adult Basic Education
- Vocational Education

The Commission decided further that the field of education offered potential for examining the use of age or age-related criteria and chose to examine admissions policies at institutions of higher education.

Following program selection, a literature review was conducted, including an analysis of the law, regulations, and guidelines and other instructions governing each program. For each program, a matrix of information was developed on the statute and regulations, with suggested subject areas of pursuit in examining program operations. The Commission also reviewed the legislative history and development of each program and applicable major studies and research and developed and analyzed program participant data by age for the most recent fiscal or calendar years, to the extent they were available.

In a real sense, the age discrimination study's first and last tasks were to generate a definition of unreasonable age discrimination and to adopt a final definition. The study developed a tentative definition of age discrimination as "any act or failure to act, or any law or policy that adversely affects an individual on the basis of age."

Findings of unreasonable age discrimination required a two-step process. First, disparities between two relevant age distributions should be demonstrated, and, second, the reason or reasons for the observed disparity must be judged justifiable or not. To facilitate the first determination, the Commission developed several operational definitions including the following:

- Age discrimination might exist to the extent that the age distribution of program beneficiaries differs from the age distribution of those eligible to benefit.

- Age discrimination might exist to the extent that the age distribution of applicants (where the "application" notion applies) differs from the age distribution of those eligible to benefit.

- Age discrimination might exist to the extent that the age distribution of those receiving benefits differs from the age distribution of those who apply for participation in the program.

- Age discrimination might exist to the extent that the age distribution of program beneficiaries is discontinuous in excess of the discontinuity that might be expected on a chance basis, (i.e., the proportion of beneficiaries in adjacent age categories differ from one another by more than would be expected if a comparable size random sample had been drawn from the applicant population and adjacent age categories compared).

- If a program provides more than one benefit or service, age discrimination might exist to the extent that the age distributions of the separate services' beneficiaries differ from one another.

- If a program uses a particular outcome or set of outcomes as an evaluation criterion or criteria, then age discrimination might exist to the extent that the age distribution of "successes" differs from the age distribution of "failures" and/or to the extent that the age distributions of the types of "successes" differ from each other.

The use of statistical evidence to establish the existence of age discrimination is important but limited. The transition from a finding of age disparities that can be statistically demonstrated to a finding of unreasonable age discrimination requires a normative judgment that cannot be statistically demonstrated. Disparities are matters of fact. Age discrimination and whether it is unreasonable are judgments concerning the explanations or reasons for the existence of disparities.

Field Study

The field study effort examined the operations of the eight selected federally-assisted programs in certain geographic areas around the country. (Adult basic education and vocational education were not studied in the field.) The field work inquiry followed from (1) an examination of the pertinent Federal statutes, regulations, and administrative policies, which revealed a basic set of common requirements for all programs that theoretically are intended to affect the use of appropriated Federal funds in delivery of services or other benefits to the eligible population; and (2) an assessment that the Commission needed to delineate the process by which program and resource allocation decisions are made to determine whether and at what point in the process program participation or benefit receipt was affected by distinctions based on age. Four major question areas resulted: planning/needs assessment; program operations and services/benefit delivery; coordination/interprogram relationships; and evaluation/outcomes.

- **Planning/Needs Assessment**— All of the programs chosen for study require that a recipient, to be eligible for Federal funds, must develop and submit to the Federal Government for approval a plan or an application. Most of the programs require the recipient to carry out some form of needs assessment of an eligible population; to establish objectives and priorities based on the result of the needs assessment; to prepare a budget that will accomplish the objectives and priorities; and to involve the public in some way in the decisionmaking process.

The Commission, therefore, looked into the processes and procedures employed by recipients of Federal funds to arrive at the final program and resource allocation decisions, reflected in their approved plans or applications.

This involved examination of, among other things, whether and how a public participation process was implemented, what interest groups were involved, and in what way, if any, the program responded to public input; how needs of the general eligible population were identified, how the relative needs of particular age groups were weighed and what influence this information had on the decisions reflected in the plan/application; what Federal, State, or local policy requirements influenced the establishment of particular program services and target group priorities, or what other factors were considered, such as the availability of other funds to provide a particular service or to serve a specific age group; and what data recipients relied on to make their plans.

- **Program Operations**— This involved looking into a recipient's implementation of its plan or application—the actual service delivery process. The Commission inquired into whether and how recipients made known the availability of their services to the potential eligible population—for example, use of information and referral and outreach, or how eligibles otherwise learned of the services; whether outreach and related activities tended to focus on certain age groups; whether recipients carried out special outreach efforts to reach particular age segments of the population; how the application process operated from point of intake (entry) to the point of successful/unsuccessful service and how applications were administered; how agencies chose among applicants when the eligible pool exceeded their resource capacities; where most referrals come from and how; whether applicants were assigned to different services or treatment plans on the basis of age; whether the recipient experienced any particular problems in providing services to certain age groups; the nature of the facilities and access to transportation; and staff background and experience.

- **Coordination/Interprogram Relationships**— Every program studied requires that a recipient of funds "coordinate" with a recipient of funds for at least one other program under study. Many of these programs are administered (at the State and local level) from a single "umbrella" or multipurpose agency, which may result in interrelationships of goals and policies. Also, eligibility for receipt of services in one program is often contingent on or related to establishment of eligibility in another, and linkages between programs may be established in reimbursement or financing arrangements. The Commission inquired into the processes employed and relationships established to effectuate these inter-program connections and their effects, if any, on the distribution of program participants by age.

- **Evaluation—** All programs require recipients to maintain records (the content varying by program) and to report periodically to the Federal funding agencies. Most programs also require recipients to conduct some form of self-assessment as to progress; others, independent audits or evaluations. The Commission examined recipients' data collection and maintenance procedures, their reporting apparatus, and the effect, if any, that self-assessment or evaluation had on who was served by the program and whether such evaluations affected whether some age groups were treated differently.

The Federal regional offices also have responsibility for monitoring the progress of the recipients' program development and operations and for ensuring compliance with the relevant Federal statutes and regulations and with their approved plans or applications. The regional office must also provide technical assistance to recipients to aid them in carrying out their program responsibilities. The Commission looked into how the regional offices executed these duties and to what extent, if at all, they influenced State and local program operations and the age of persons receiving services or benefits under the program.

The field study was conducted in six sites:

- San Antonio, Texas
- St. Louis, Missouri
- Jackson, Mississippi
- Seattle, Washington
- Augusta and the State of Maine
- Chicago, Illinois

Work was also done in their respective State capitals and Federal regional office cities.

Several considerations guided the Commission's selection of field study sites. These included choosing a mix of field sites that would be characterized as:

- dispersed across the country;
- varying by population size;
- including a proportion of their population over 65 years of age, and over 65 years of age with incomes below the poverty level;
- having a viable number of minorities;

- varying by urban/rural mix;

- having active projects in all of the federally-assisted programs selected for field review.

The sites selected for the field study and the public hearings (except Washington, D.C.) with selected demographic characteristics are listed at the end of this section. An additional factor involved the likelihood of obtaining current demographic data for selected locations.

Field study consisted of onsite interviews regarding planning, program operations, coordination, and evaluation with local program administrators and service delivery operatives, State government administrators, Federal regional office staff responsible for overseeing and enforcing implementation of program statutes and regulations, and advocate groups at the local and State levels. State and local plans or applications, data on numbers of program participants by age, and other available information were obtained during this process and then reviewed.

The Commission approached the field study in higher education independently of its inquiry into the eight federally-assisted programs. The Commission was interested primarily in the use of age as a factor in admission policies and procedures; the variations in age-related policies among disciplines within a single institution or among various fields of study, i.e., medicine, law, engineering, social sciences; the relationship of age to other entrance criteria, i.e., grade point average, standardized test scores, and related factors; and the relationship of age to academic success.

Since research into higher education was solely concerned with the use of "age" as a criterion for decisionmaking and since the area did not interrelate with the other federally-assisted programs, the Commission determined that considerations for program field study sites need not control for selection of the educational institutions studied. Indeed, the most important variable was the kind of institution and secondarily its geographic location. Because of available resources, the Commission decided to confine its efforts with regard to education to areas close to Washington, D.C., except that work would also be done in the sites selected for public hearings. The Commission selected 52 institutions of higher education, taking into account factors such as size of enrollments; whether they were 2-year or 4-year institutions and had graduate and professional schools; and whether they were publicly maintained (Federal, State, local, State and local, and State-related) or privately controlled institutions. The Commission's interviews involved the following types of educational officers, though not all types were interviewed at every institution:

Director of Admissions

Director of Financial Aid

Director of Career Planning/Placement

Director of Counseling/Testing

Registrar

Dean of Undergraduate Admissions

Dean of Graduate Admissions

Dean/Admission Officer for Law

Dean/Admission Office for Medicine

Dean/Admission Officer for Education

Dean/Admission Officer for Business

Dean/Admission Officer for Dentistry

Dean/Admission Officer for Social Work

Dean/Admission Officer for Engineering

Personnel/Curriculum Development Officer

Before going to any site, all available relevant information about a program's operation was collected and reviewed. In addition, interviewees were requested to have available at the time of their interview any public notices about the program, outreach materials, annual reports, statistical summaries, needs assessments, and program evaluations that the agency might have prepared. They were also furnished an advance list of the issues that would be pursued during the interview.

Public Hearings

The act directs the Commission as part of its study to hold public hearings *to elicit the views* of interested parties, including Federal departments and agencies on age discrimination and, particularly, on the reasonableness of using age to distinguish among potential beneficiaries of federally-assisted programs. It appears that the Congress expected the Commission, as part of its obligation, to produce not only a record of fact from whatever analysis and investigation it might pursue, but also a record of viewpoint obtained primarily through a hearings process. The Commission saw the hearings as an opportunity to expand the information it had developed through the field study and to gather and record the views of public officials and others on the act and the "reasonableness" of age or age-related distinctions.

One basic consideration influenced the Commission's decision on the number and location of the hearings—a desire to broaden the geographic coverage of the study. This involved a concern for producing a final record of data and viewpoints from most regions of the country, and thus a more generally applicable report.

After considering these factors and assessing available resources and time constraints, the Commission decided that it would hold four public hearings, three of which would be oriented to programs in the specific hearing location and a fourth, a national hearing in Washington, D.C.

The choice of hearing sites involved essentially the same criteria as those used to select the field study sites. The Commission also wanted to expand its effort to the extent possible to cover those Federal regional areas not covered in the field study. After weighing demographic information on a number of possible sites for the three field hearings, the Commission selected San Francisco, Denver, and Miami. San Francisco was selected primarily to ensure representation of the largest State in the nation and because of the city's unique racial/ethnic composition. Denver was chosen because of its status as one of the few large cities in the Great Plains/Rocky Mountain area, with the expectation that administrators in that area could address the concerns that might be unique to rural areas. The Miami area includes one of the country's largest concentrations of older people, the group that is a primary concern of the act's drafters. Demographic information for the hearing sites is listed at the end of this section.

The Washington, D.C., hearing was intended to be the culmination of the hearings process and field work operations. Unlike the others, the Washington, D.C., hearing was to have a national and summary thrust. Because of these different purposes, the Commission devised two approaches and two sets of objectives for meeting the hearing obligation. The following objectives were established for its hearings in San Francisco, Denver, and Miami:

- To build on and expand the body of information acquired from the field review by receiving testimony that would contribute to substantiating, refining, refuting, or otherwise altering preliminary findings of the nature, cause, and extent of age discrimination.

- To draw in administrators and others to explain program behavior that causes or contributes to selecting out, directly or indirectly, potential clients, beneficiaries, or participants on the basis of age.

- To solicit viewpoints as to what might be considered reasonable conditions for distinguishing among potential clients, beneficiaries, or participants on the basis of age.

- To solicit recommendations for suggested general regulations and Federal enforcement procedures to implement the act.

The Commission conducted, as well, a field review of program operations in the hearing sites similar to that conducted in the field study sites. The Commission adhered closely in its preliminary work for the hearings to the same procedures and processes followed in the field work. All relevant program information was reviewed before going to hearing sites, and responsible local, State, and Federal officials were interviewed in advance of the hearing itself. Questioning at the hearings covered the same subject areas as the field study. The following types of witnesses testified at all of the field hearings:

- Federal regional office representatives; State and local government and private agency program administrators; program planners; and providers of social, health, and employment service.

- Other Federal, State, and local officials, including members of Congress, lieutenant governors, State legislators, and mayors.

- Advocate organizations for specific groups, including State and area offices on aging and private aging advocates, child welfare organizations, and youth advocates.

- Civil rights organizations' representatives.

- Administrators of institutions of higher education.

- Consumers and beneficiaries of services or other assistance.

The hearing in Washington, D.C., differed from the others in its focus on a national overview of the issues. By that time, the Commission had completed an extensive study of 8 Federal programs in 6 areas of the country and had investigated 52 institutions of higher education. Through these efforts the Commission had identified a series of issues and problems that appeared to be common to each of the programs examined indepth and to other federally-assisted efforts and program-specific issues. The Commission established three general objectives for the Washington, D.C. hearing:

- To solicit the viewpoints and recommendations of Federal agency officials and representatives of selected national organizations on the general and specific issues generated by the study efforts.

- To solicit testimony on issues or problems connected with the current provisions of the Age Discrimination Act and on whether these provisions should be changed, and if so, in what way.

- To solicit testimony on what recommendations the Commission might make about coordination of the intergovernmental processes associated with implementation of the act and the Federal leadership role in eliminating age discrimination.

While the field hearings focused on Federal, State, and local officials responsible for the programs under study, a somewhat different array of witnesses was assembled for the Washington, D.C., hearing. The Federal programs examined indepth had been selected in part for their "representativesness" within the Federal grants structure. Although in some instances problems had been identified that seemed peculiar to only one program, the primary objective had been to establish patterns by which to suggest, to the extent the evidence allowed, that the identified problems probably existed in other programs not covered by the study but within the purview of the act. The Washington, D.C., hearing, therefore, included not only those Federal officials responsible for the eight programs and the area of education, but others whose programs would be subject to the act. In addition, national organizations with an interest in the programs reviewed or in the issue of age discrimination were called to testify. These included professional organizations created to advocate the interests of certain vulnerable, disadvantaged, or discriminated against groups (for example, civil rights groups, aging organizations).

Selected Demographic Characteristics of Field Study and Public Hearings Sites, Excluding Washington, D.C.

		TOTAL U.S.	243 SMSA's	Chicago Ill.	Denver Co.[a]	Jackson Ms.	Miami Fla.[a]	St. Louis Mo.	San Antonio Tx.	San Francisco Ca.[a]	Seattle Wa.	Augusta/ Kennebec Co. Me.
SMSA	Rank of SMSA	b	b	3	27	121	25	10	38	6	17	
	Population	203,212,877	139,418,047	6,974,906	1,227,906	258,906	1,267,792	2,263,017	864,014	3,109,519	1,421,869	b
	# Black	11.1	12.0	17.6	4.1	37.2	15.0	16.7	6.9	10.6	2.9	b
	# Spanish	4.6	5.5	4.7	11.3	0.3	23.6	0.9	44.6	11.7	1.7	b
	# 65+	9.9	9.3	8.9	7.8	8.0	13.7	9.9	7.7	9.6	8.5	b
	# 65+ in poverty	19.3	19.1	18.0	15.9	12.6	22.7	20.9	11.4	15.3	21.8	b
Central City	Rank of City			2	25	90	42	18	15	31	22	b
	Population			3,362,825	514,678	153,968	335,075	622,236	654,289	715,674	530,890	95,245
	# Black			32.7	9.2	39.7	22.8	40.9	7.6	13.4	7.1	b
	# Spanish			7.4	16.8	0.3	45.3	1.0	52.2	14.2	2.0	b
	# 65+			10.6	11.5	8.0	14.5	14.7	8.4	14.0	13.1	11.7
	# 65+ in poverty			16.4	18.1	11.7	21.0	20.2	11.3	18.9	25.0	24.0

[a] Hearing site

[b] Not applicable and/or less than 0.1%

Source: 1972 City and County Data Book, U.S. Bureau of the Census

Chapter 1

Social Services Under Title XX of the Social Security Act

Title XX of the Social Security Act authorizes grants to States for part of the cost of providing social services to individuals and families.[1] States may elect to provide, within guidelines set forth by the law and by the Secretary of Health, Education, and Welfare, any services directed at enabling an individual or family to meet any of the five goals of the program. These goals are: achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency; achieving or maintaining self-sufficiency including reduction or prevention of dependency; preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests or preserving, rehabilitating, or reuniting families; preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; or securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.[2]

Review of the Title XX social services program revealed discrimination on the basis of age in several areas. State legislatures, in making decisions about how funds for social services will be spent, convert the Title XX program into a program for certain age groups by mandating age-specific programs. State and local program administrators, without authorization in Federal law, also employ policies and practices that restrict participation in services supported under Title XX to certain age groups.

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[1] Social Services Amendments of 1974, Pub. L. No. 93-647, 88 Stat. 2337 (1974); *as amended by* Pub. L. No. 94-120, 89 Stat. 609 (1975); Pub. L. No. 94-401, 90 Stat. 1215 (1976) [codified at 42 U.S.C.A. §§1397-1397f (West Supp. 1977)].

[2] 42 U.S.C. §1397 (Supp. V 1975).

The Commission found that States' allocation of social service funds follows historical patterns of spending under which different age groups have not been treated equitably. By adhering to these patterns, administrators have continued the inequities. Another area of discrimination on the basis of age identified by the Commission was that agencies and organizations with whom States contract for the provision of services set unauthorized age limits for participating in their programs.

The Commission also found that outreach is either not conducted, or is conducted in a very limited way that results in some age groups not knowing about or having access to the programs. Finally, the Commission found that the existence of other funds for services programs for older persons is used by administrators to justify their not making Title XX resources available to older persons on an equitable basis.

Program Description

The Social Services Amendments of 1974 were signed into law on January 4, 1975, and added a new Title—Title XX—to the Social Security Act of 1935.[3] Title XX consolidated social services programs that had been in effect previously and authorized States to expand their population coverage and provision of social services. It replaced the social services provisions of Title IV–A of the act, aid to families with dependent children,[4] and the social services authorized under Title VI of the act for low-income aged (65 or over), blind, and disabled persons receiving of Supplemental Security Income (SSI) and/or State supplements to the Federal SSI payment.[5]

The new law granted more discretion to State governments than they had under the previous programs to decide whom to serve and what social services to provide. Title IV-A and Title VI had mandated the provision of specific packages of services in order for States to receive Federal reimbursement for social services.[6] Title XX establishes broad program goals to which services a State elects to provide must be directed:

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[3] Social Services Amendments of 1974, Pub. L. No. 93–647, 88 Stat. 2337 (1974); *as amended by* Pub. L. No. 94–120, 89 Stat. 609 (1975); Pub. L. No. 94–401, 90 Stat. 1215 (1976) [codified at 42 U.S.C.A. §§1397–1397f (West Supp. 1977)].

[4] 42 U.S.C. §§601–609 (1970).

[5] Social Security Amendments of 1972, Pub. L. No. 92–603, §302, 86 Stat. 1329 (1972). Cash assistance for the aged, blind, and disabled existed prior to the passage of the 1972 amendments as Titles I, X, XIV, and XVI of the Social Security Act as it had been subsequently amended [codified at 42 U.S.C. §§301–306, 1201–1206, 1351–1355, 1381–1385 (1970)]. The 1972 amendments which consolidated and altered these assistance provisions under newly created Titles VI (Grants to States for Services to the Aged, Blind or Disabled) and XVI (the Supplemental Security Income Program) of the Social Security Act were made effective Janaury 1, 1974. Title VI was then repealed when Title XX was enacted in 1975. Both cash assistance and social services for low-income, dependent children and their relatives were authorized under Title IV–A of the Social Security Act. When the Title XX program was enacted, States were still required to provide services to dependent children receiving cash assistance, but were required to do so as part of the new Title XX program. 42 U.S.C. §1397a(a)(4)(A) and (B) (Supp. V 1975).

- achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
- achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;
- preventing or reducing inappropriate institutional care by providing for community-based care or other forms of less intensive care; or
- securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.[7]

The law also specifies types of expenditures for which a State may not receive Federal reimbursement.[8]

Within the boundaries of these goals and limitations, the Federal government will reimburse the States for any services directed at the program's goals. The broad discretion of the States in choosing services is suggested by the following provision of the act:

> . . .the Secretary may not deny payment. . .to any State with respect to any expenditure on the ground that it is not an expenditure for the provision of a service or is not an expenditure for the provision of a service directed at a goal. . . .[9]

In other words, unless the law prohibits an expenditure, Federal reimbursement of a service claimed by a State may not be disallowed on the ground that it is not, in fact, a Title XX service.

Title XX also gives States discretion to provide services to persons who had not been eligible for social services under the previous programs. To receive social services under the Title IV-A and VI programs, persons had to be current, former, or potential recipients of, or applicants for, cash assistance under AFDC or SSI.[10] This meant that they had to be either 65 or over, blind, or disabled, or have dependent children to qualify for social services. Under the Title XX social services program, individuals may receive social services if they receive AFDC payments or have their needs taken into account in determining the needs of an individual who receives AFDC payments, if they receive SSI program benefits or State supplementary payments, or if they are members of families who have incomes within a maximum allowable level permitted to be established by each State.[11]

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[6] 45 C.F.R. §§220.15–220.24, 220.40–220.47 (1973).

[7] 42 U.S.C. § 1397 (Supp. V 1975).

[8] 42 U.S.C.A. §1397a(a)(7)–(13) (West Supp. 1977).

[9] 42 U.S.C. §1397a(a)(3) (Supp. V 1975).

[10] Public Welfare Amendments of 1962, Pub. L. 87–543, Title I, §§101(a)(1), (b)(1)(a), 76 Stat. 173 (1962).

The income eligibility provision enables States, if they choose, to serve previously ineligible persons—persons without dependent children and who are not aged, blind, or disabled. The act requires, however, that 50 percent of all Federal funds paid to a State for Title XX services expenditures be spent to assist persons who receive or are eligible to receive cash assistance under AFDC, SSI benefits, or State supplementary payments; persons whose needs are taken into account in determining the needs of AFDC recipients or who are eligible to have their needs taken into account in determining the needs of AFDC recipients or eligibles; persons whose income and resources are taken into account in determining the amount of SSI benefits or State supplementary payments being paid to an individual, or whose income and resources would be taken into account in determining the amount of such benefits or payments to be paid to an eligible individual; or persons eligible for assistance under the Medicaid program.[12]

Title XX does not prescribe specific income levels that States must establish; rather, it establishes the maximum level above which persons are not eligible—115 percent of the median income of a family of four in the State, adjusted for family size in accordance with regulations prescribed by the Secretary.[13] The act also provides that if a State elects to provide services to persons whose incomes exceed 80 percent but not 115 percent of the median income, the State must charge those persons a fee.[14] States may also charge fees to persons with incomes at or below 80 percent of the median, but the statute does not require it.[15] A State may establish different income criteria for different services, different categories of individuals, or different geographic areas.[16]

The median incomes and the income criteria selected by the States included in the Commission's study are presented in table 1.1. They show the wide variation in States' decisions on setting income eligibility levels. In some States, income eligibility levels are the same for all or most services. In other States, several different income levels have been established for different services.

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[11] 42 U.S.C. §1397a(a)(5) and (6) (Supp. V 1975).

[12] 42 U.S.C. §1397a(a)(4) (Supp. V 1975). "State supplementary payments" are those cash payments made by a State on a regular basis to a person receiving SSI benefits or to a person who would, but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits. §1397f(1) (Supp. V 1975).

[13] 42 U.S.C. §1395a(a)(6) (Supp. V 1975). Median incomes are adjusted for family size according to the following percentages: one person—52 percent; two-person family—68 percent; three-person family—84 percent; four-person family—100 percent; five-person family—116 percent; six-person family—132 percent; for each additional family member above six persons, the State shall add 3 percentage points to the percentage for a family of six. 42 Fed. Reg. 5842, 5858 (1977) (to be codified in 45 C.F.R. §228.60(d)(2)).

[14] 42 U.S.C. §1397a(a)(6) (Supp. V 1975).

[15] 42 U.S.C. §1397a(a)(5) (Supp. V 1975).

[16] 42 Fed. Reg. 5842, 5851 (1977) (to be codified in 45 C.F.R. §§228.24–228.25).

Table 1.1

Median Income and Eligibility Levels for Families of Four for Selected States for October 1, 1976, through September 30, 1977

State	Median[a] Income	80% of[a] Median	115% of[a] Median	Eligibility Standards[b]
California	15,831	12,745	18,321	The State level for services for all counties but one is 80%, except for the following services: *AFDC* Employment *SSI* Work activity/workshops and programs for Developmentally Disabled Individuals *SSI/Income Eligible (80%)* Out-of-Home Care for Adults In-Home Supportive Services (Only eligible if meet all but income criteria for SSI) *84%–115% Median Income* Child Day Care—84% except current consumer or protective case; then eligibility to 115%
Colorado	15,629	12,503	17,973	80% except for Adult Foster Care, which is limited to SSI and Assistance Payment status
Florida	14,788	11,830	17,006	All services available to 61% except legal services (36%) and Nursing Home Services (73%)
Illinois	16,350	13,080	18,803	*AFDC* Legal Services *AFDC–SSI* Day Care for Adults *AFDC/SSI and General Assistance to (80%)* Chore and Housekeeping Service Health Related Services Home and Financial Management Housing Improvement Employment Services Education and Training Transportation *65%* Unmarried Parents Services *80%* Adoption Day Care for Children Day Training for Special Needs Foster Care Services for the Blind and Partially Sighted Services to the Handicapped Short Term Evaluation Social and Rehabilitation Services Transitional Services *115%* Homemaker Outpatient Drug Abuse Services Residential Treatment Outpatient Services Work Release

Table 1.1 (cont'd)

Median Income and Eligibility Levels for Families of Four for Selected States for October 1, 1976, through September 30, 1977

State	Median[a] Income	80% of[a] Median	115% of[a] Median	Eligibility Standards[b]
Maine	12,552	10,042	14,435	All services available to 72% of median income except for Campership, which is limited to AFDC recipients or essential persons, child welfare recipients, or handicapped or retarded children
Mississippi	11,562	9,250	13,296	All services available to 80% of median income except for Day Care for Children and Adults, Work Activity Service, services for developmentally disabled children, all of which are available to 115%
Missouri	13,770	11,016	15,836	All services available to 80% of income
Texas	13,924	11,139	16,013	26 of Texas' 34 services are available to 60% 8 additional services are available to aged, blind, and disabled adults to 65% of the median chore services, family care services, homemaker services, day activity services, home delivered or congregate meals, special services provided by foster family homes, health related services and alternate living plans
Washington	15,401	12,321	17,711	Services are available to 80% of the median with the following exceptions: • Home Delivered Meals, available to recipients of SSI or the State-Supplemental payment • The State medical assistance program (FAMO) which covers persons to 80% of median income • Family Planning and Alcoholism services limited to 50% • Chore Services limited to 50% for families and 57% for single persons

Source: [a] U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Action Transmittal, SRS-AT-76-4 (CSA)* January 8, 1976
[b] U.S., Department of Health, Education, and Welfare, Office of the Assistant Secretary for Planning and Evaluation, *Technical Notes: Summaries and Characteristics of States' Title XX Social Services Plans for Fiscal Year 1977*, pp. 8-31.

As a result of 1976 amendments to the act, a State may elect to provide social services to persons on the basis of their membership in a "group," without individual determination of eligibility, if the State concludes that substantially all of the persons who receive the service are members of families whose monthly gross income is not more than 90 percent of the median income of a family of four in the State, adjusted for family size.[17]

Information or referral services, protective services for children and adults, and family planning services are available to persons regardless of their income, if a State elects to provide such services.[18]

Although Title XX allowed States to expand the types of services they can offer and to extend coverage to individuals not previously eligible for social services, the act did not increase the level of Federal funding available to support social services. The social services programs under Title IV-A and Title VI of the Social Security Act had authorized the Federal Government to reimburse States for 75 percent of their legitimate expenditures for social services.[19] No limit on appropriations existed for these programs until 1972, when the Congress placed a $2.5 billion ceiling on the funds that the Federal Government would make available.[20] When the Congress passed the Title XX social services program, the $2.5 billion ceiling (excluding funds for personnel training or retraining) was retained.[21] The law provides for a formula, based primarily on the ratio of the population of each State to the population of the 50 States and the District of Columbia, by which the $2.5 billion is distributed among the States, and thus limits the expenditures for which a State can be reimbursed with Federal funds.[22] Although a State can spend more than its Federal allotment for social services, it is not reimbursed with Federal funds for expenditures exceeding its ceiling. The Federal Government reimburses 75 percent of each State's allowable expenditures for all social services except family planning, for which the Federal Government reimburses 90 percent of a State's costs.[23]

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[17] 42 U.S.C.A. §1397a(a)(14)(A) (West Supp. 1977). Child day care services except for services provided to a child of a migratory agricultural worker are excluded from the group eligibility authorization (§1397a(a)(14)(B)). In addition, Federal regulations require that except for runaways, eligibility determination for services directed at the goal of preventing or remedying neglect, abuse, or exploitation of children or adults unable to protect their own interests (commonly referred to as "protective services") must be made on an individual basis. 42 Fed. Reg. 5842, 5861 (1977) (to be codified in 45 C.F.R. §228.65(b)).

[18] 42 U.S.C.A. §1397a(a)(6) (West Supp. 1977). Although family planning services are not mandated to be provided under the provisions of Title XX, Title IV of the Act (Aid to Families With Dependent Children) requires that as a condition to receiving funds under Title IV-A, the State Title IV-A plan must provide as part of the State's program for the provision of services under Title XX for the development of a program for each appropriate relative and dependent child receiving AFDC and for those whose needs are taken into account in determining eligibility for AFDC, for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases (including minors who can be considered to be sexually active) family planning services are offered to them. 42 U.S.C. §602(a)(15) (Supp. V 1975).

[19] Public Welfare Amendments of 1962, Pub. L. 87-542, Title I, §101(a)(1), (b)(1)(s) and (b)(2) (A)-(C), 76 Stat. 1973 (1962).

[20] Act of Oct. 20, 1972, Pub. L. No. 92-512, Title III, §301(b)(1), 86 Stat. 946.

[21] 42 U.S.C. §1397a(a)(2)(A) (Supp. V 1975).

[22] 42 U.S.C. §1397a(a)(2) (Supp. V 1975).

Retention of the $2.5 billion ceiling meant that States that had been spending at their ceiling under Title IV-A and Title VI were not in a position to expand their social services programs under Title XX or to offer services to newly eligible persons unless they did so with State monies.[24] In addition, because of population shifts that caused allocation of the $2.5 billion to differ from that under the Title IV-A and Title VI programs, several States actually received less Federal funding under Title XX than under the previous programs.[25] Few States, however, had been spending their full allotment of Federal funds under the earlier programs, so most of them did have the opportunity to expand their services and/or extend coverage to persons previously ineligible to receive services.[26]

To be eligible to receive Title XX funds, each State must develop a State plan and a services plan.[27] The State must submit the State plan to the Secretary of Health, Education, and Welfare for approval.[28] To be approved, the State plan must provide, among other things, that the chief executive officer of the State, or as otherwise provided by the laws of the State, will designate an appropriate agency to administer or supervise the administration of the State's program of Title XX social services; that an opportunity for a fair hearing before the appropriate State agency will be granted to any individual whose claim for a Title XX social service is denied or is not acted upon with reasonable promptness; that use or disclosure of information obtained in connection with the administration of the State's Title XX social services program concerning applicants for and recipients of those services will be restricted; that no durational residency or citizenship requirement will be imposed as a condition to participate in the program; that if the State Title XX program includes services to individuals living in institutions or foster homes, a State authority or authorities which shall be responsible for establishing or maintaining standards for such homes will be designated or established; that the program will be in effect in all political subdivisions of the State; that if the program includes child day care services, a State authority or authorities which shall be responsible for establishing and maintaining standards for such services will be designated or established; and that the State will participate financially in the provision of services.[29] Most States have designated the State agency that previously had responsibility to administer Title IV-A and Title VI, generally called the department of public welfare, department of public aid, or the human services agency, as the agency responsible for the Title XX program.[30]

The State agency designated to administer or supervise the administration of the Title XX social services program is responsible for preparing the services plan, called the comprehensive annual services program plan (CASP).[31] The CASP must set forth the State's plan for the provision of Title XX services during the year, including, among other things,

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[23] 42 U.S.C. §1397a(a)(1) (Supp. V. 1975).

[24] Jerry Turem and others, *The Implementation of Title XX: The First Year's Experience* (draft) (Washington, D.C.: The Urban Institute, 1976), p. 9 (hereafter cited as *Implementation of Title XX*).

[25] Ibid.

[26] Ibid.

[27] 42 U.S.C. §1397b(d)(1), 1397c (Supp. V 1975).

[28] 42 U.S.C. §1397b(d)(2) (Supp. V 1975).

[29] 42 U.S.C. §1397b(d)(1) (Supp. V 1975).

[30] Turem, *Implementation of Title XX*, p. 51.

- the objectives to be achieved under the program;

- the services to be provided under the program, including at least one service directed at at least one of the five program goals (as determined by the State) and including at least three types of services (selected by the State) for SSI beneficiaries who are in need of such services, together with a description of their relationship to the objectives of the program and the goals of the Act;

- the categories of individuals to whom those services are to be provided, including any categories based on the income of individuals and their families;

- the geographic areas in which those services are to be provided, and the nature and the amount of the services to be provided in each area;

- a description of how the provision of services under the program will be coordinated with the AFDC, Child-Welfare Services, SSI, and Medicaid programs, and with other human services programs within the State, including the steps taken to assure maximum feasible utilization of services under these programs to meet the needs of the low-income population;

- a description of the steps taken, or to be taken, to assure that the needs of all residents of, and all geographic areas in, the State were taken into account in the development of the plan.[32]

Unlike the State plan, the CASP is not submitted to the Federal Government for approval, but is approved by the chief executive officer of the State, unless the State's laws provide otherwise.[33] Each State's CASP is also reviewed by the appropriate Federal regional official for conformity with the requirements of the law.[34]

Decisions on the types of services to be provided, persons eligible for benefits and services, the geographic areas where services will be offered, and other provisions set forth in the CASP are subject to public comment.[35] At least 90 days before the beginning of the period a State has established as its services program year, the chief executive officer of the State, or other official designated by State law, must publish and make available to the public a proposed CASP.[36] Public comment on the proposed CASP must be accepted for at least 45 days, after which the final CASP must be published, with an explanation of the differences between the proposed and final plans.[37] Any amendments to the final plan, including changes made in the geographic coverage of the program, the services offered, the fees charged, or the categories of persons to be served, must also be published and made available to the public.[38] No payment may be made under Title XX unless these CASP requirements are met.[39]

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[31] 42 U.S.C. §1397c(2) (Supp. V 1975).

[32] *Id.*

[33] *Id.*

[34] 42 Fed. Reg. 5842, 5858 (1977) (to be codified in 45 C.F.R §228.34).

[35] 42 U.S.C. §1397c(2) (Supp. V 1975). The act indicates that the publication of the proposed comprehensive annual services program plan is for the purpose of assuring public participation in the development of the program for the provision of the services to be provided under Title XX. §1397c.

[36] *Id.*

[37] 42 U.S.C. §1397c(3) and (4) (Supp. V 1975).

The designated State agency may provide services directly to individuals—through its own staff and facilities—or it may provide services through contractual arrangements with other public or private agencies and organizations.[40]

The State agency may elect to have some or all of the service providers with whom it contracts determine individuals' eligibility to receive services.[41] Where this is done, the individual may contact the provider agency directly for services. If the provider is not authorized to determine eligibility, the individual must either go to the agency where eligibility is determined or be referred to that agency by the provider to have his or her eligibility determined. States may receive Federal reimbursement only for providing services that are included in the CASP.[42]

Title XX is administered at the Federal level by the Administration for Public Services, Office of Human Development Services, Department of Health, Education, and Welfare.

Summary of the Record

Program Participants

Each State participating in the program must make such reports concerning its use of Title XX funds as the Secretary requires in regulations.[43] Federal regulations require simply that each State maintain or supervise the maintenance of records necessary for the proper and efficient administration of the program, including records regarding applications, determination of eligibility, the provision of services, and administrative costs, in such form and containing such information as the Secretary may from time to time require.[44] The specific social services reporting requirements (SSRR) that States must follow have been set forth to the States in an *Action Transmittal*, which requires States to provide information quarterly and annually on recipients by category of eligiblity, goals and services, and costs.[45] These data may be collected by 100 percent reporting, sampling, or a combination of these techniques.[46]

The reporting requirements do not, however, provide a basis for developing data on participants in the Title XX social services program by age. Recipients of social services are reported by category of eligibility—that is, whether the individual receiving social services is eligible based on receipt of AFDC, SSI (and within this category, whether the individual is aged, blind, or disabled), or Medicaid; on income; on need for services provided without regard to income; and by the number of child recipients and adult recipients within each of the eligibility categories. States are not required to report the ages of recipients of services.[47]

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[38] 42 U.S.C. §1397c(5) (Supp. V 1975).

[39] 42 U.S.C. §1397a(a)(3)(A) (Supp. V 1975).

[40] 42 Fed. Reg. 5842, 5862 (1977) (to be codified in 45 C.F.R. §228.70).

[41] 42 Fed. Reg. 5842, 5860 (1977) (to be codified in 45 C.F.R. §228.61(e)). In order for the provider to determine eligibility, the contract between the State agency and the provider must provide for eligibility determination by that provider.

[42] 42 U.S.C. §1397a(a)(3)(B) (Supp. V 1975).

[43] 42 U.S.C. §1397b(a) (Supp. V 1975).

[44] 42 Fed. Reg. 5842, 5850 (1977) (to be codified in 45 C.F.R. §228.17).

[45] U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Action Transmittal: Social Services Reporting Requirements (SSRR)* (July 1975) pp. 3-1, 3-2 (hereafter cited as *Action Transmittal*).

[46] Ibid., p. 3-3.

The social services reporting requirements state that "some of the forms in the Social Services Reporting Requirements require counts of all social services recipients; others require counts of Primary Recipients only." For purposes of these reports, a primary recipient is considered to be—

> . . .an individual with whom or for whom a specific goal has been established and who received social services for the purpose of achieving that goal. Services may also be provided to members of the Primary Recipient's family in order to facilitate achievement of the Primary Recipient's goal. These services would therefore be considered to be received by the Primary Recipient. Under the Primary Recipient concept, there may be more than one Primary Recipient in a given family if the level of problem indicates the desirability of establishing a goal for the individual child or adult members of the family. Thus, each member of a family with whom or for whom a specific goal has been established and who receives social services directed at the achievement of that goal is considered to be a Primary Recipient.[48]

For example, if a caseworker determined that an AFDC mother needed day care for her children in order to be able to work, the caseworker would report that an adult was the primary recipient of child day care even though a child actually received the service. The child's (or children's) receipt of the service might not be reported at all. This type of reporting is fairly commonplace; State agencies responsible for Title XX reported to the Department of Health, Education, and Welfare that for the period between April and June 1976, 71 percent of the recipients of day care services for children were adults, and 29 percent were children.[49]

Most of the reporting forms require that States report on primary recipients of services—the persons for whom goals are established—rather than on all persons served or the persons who actually receive a service.[50] Because of this method of counting primary recipients, even the data available on the number of children and adults served under the program do not provide adequate information to assess the ages of program participants.

Another limitation on the Title XX data is that in reporting most of the information on social services submitted by the States, the Department of Health, Education, and Welfare consolidates the data on

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[47] Ibid., p. 3–6.

[48] Ibid., pp. 3–1, 3–2.

[49] U.S., Department of Health, Education, and Welfare, Office of Human Development Services, *Social Services U.S.A. April–June 1976*, Pub. No. (DHDS) 77–0330, 1977, p. 7 (draft) (hereafter cited as *Social Services U.S.A. April–June 1976*).

[50] *Action Transmittal*, pp. 3–6 and 3–10—3–28.

Title XX with data on the States' services to recipients of social services under Title IV–B (Child-Welfare Services) and Title IV–C (WIN) of the act.[51]

Inclusion of these programs changes to some degree the distribution of resources within categories of recipients, as shown by data available for January through March 1976. These data indicate that of all primary recipients who received services under Title XX for the quarter January through March 1976, 33 percent were reported as children and 67 percent as adults. Of those persons, 41 percent were recipients of AFDC, 17 percent received SSI, 30 percent received services on the basis of their income, and 12 percent received services without regard to their income. Within these groups, 43 percent of all services recipients who were AFDC eligibles were children and 57 percent were adults; 24 percent of persons receiving services on the basis of their income were children and 76 percent were adults; 5 percent of persons receiving social services based on their status as SSI recipients were children and 95 percent were adults; and 57 percent of persons receiving social services without regard to income were children and 43 percent were adults.[52] These data are presented in chart 1.1.

Data on the children and adults receiving services under Title XX, Child-Welfare Services, and WIN for that same period, which are presented in chart 1.2, show that 38 percent of all social services recipients were AFDC eligibles; 28 percent (4 percent of whom were Medicaid eligibles) were eligible on the basis of their income; 15 percent were receiving or eligible for SSI; 11 percent were receiving services without regard to their income; 6.7 percent were AFDC-WIN eligibles; and 2 percent were receiving or eligible for child-welfare services.[53]

The Commission was told that the lack of data by age on recipients of social services under Title XX presents difficulties for advocates for the groups trying to influence the allocation of services and resources under the Title XX program. Advocates for older persons made particular note of this problem. George Tsismanakis, executive director of the Gulfstream Areawide Council on Aging in Florida, testified that the Florida Department of Health and Rehabilitative Services, the agency administering the Title XX program—

> . . .cannot provide data—or will not provide data—showing the number of elderly who are served under Title XX. . . .
>
> The omission of information, the lack of available information, and the lack of research, well within the State's command, suggests very strongly that there is discrimination against the elderly under Title XX.[54]

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[51] U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Social Services U.S.A. January–March 1976*, Pub. No. (SRS) 77–03300, 1977, p. 5 (hereafter cited as *Social Services U.S.A. January–March 1976*).

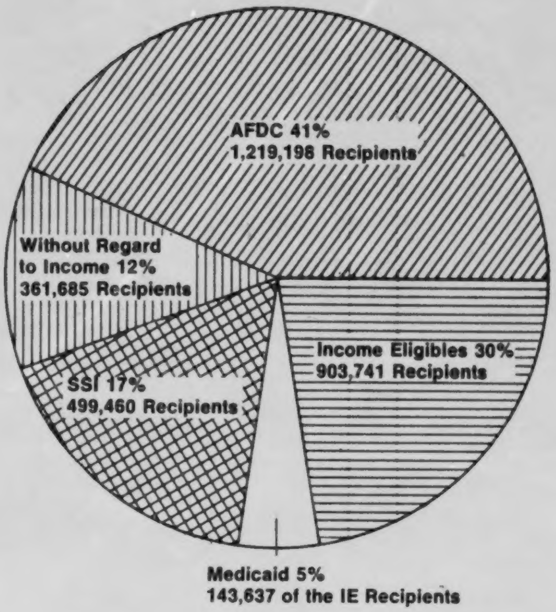
[52] Ibid., p. 2.

[53] Ibid., p. 3.

[54] George Tsismanakis, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida*, August 22–23, 1977, vol. I, pp. 198–199 (hereafter cited as *Miami Hearing*).

Chart 1.1

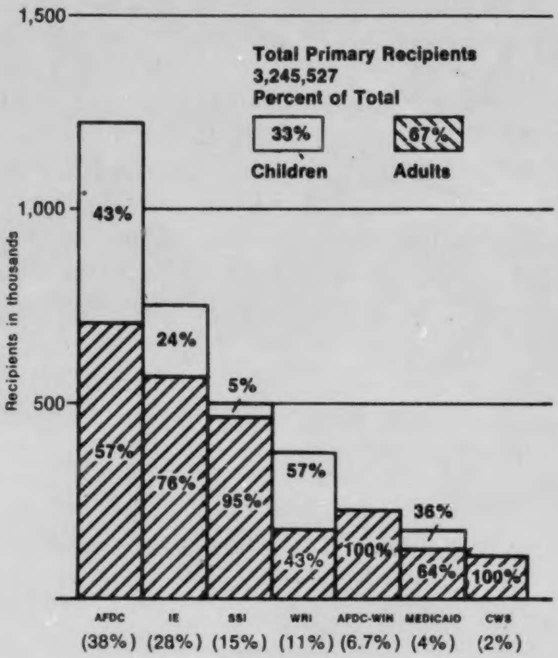
Number of Primary Recipients of Social Services Under Title XX by Category of Eligibility



Source: U.S., Department of Health, Education, and Welfare, *Social Services U.S.A. January-March 1976* (1977), p. 2.

Chart 1.2

Adult and Child Primary Recipients of Social Services, by Category, Funded Under Title XX, Title IV-B, and Title IV-C During January-March 1976



AFDC = Recipients of Aid to Families with Dependent Children
IE = Income Eligible
SSI = Recipients of Supplemental Security Income
WRI = Eligible Without Regard to Income (Covers family planning, protective services and information and referral)
CWS = Recipients of Child Welfare Services under Title IV-B of the Social Security Act
WIN = Work Incentive Program enrollees

Source: U.S., Department of Health, Education, and Welfare, *Social Services U.S.A. January-March 1976*, (1977), p. 3.

Gilbert Murphy, executive director of Seniors! Inc., Denver, Colorado, testified:

> . . .Services to the elderly are classified as adult services. So into the general classification of all adult services would go those. . .people over the age of 60 or 65, and it is very difficult in the Title XX plan in the State to ferret out exactly what services are being delivered to the elderly or to the senior citizens. This makes it impossible for those of us who like to make a case of discrimination to ferret out enough information from the plan to provide hearing testimony for our department and to clarify how much of this service actually goes to the elderly. There is no specific definition of services for the elderly in the plan. This is discriminatory because it does not allow for analysis of the actual delivery of services to older people.[55]

Despite the lack of age data, the Commission did determine through the field study and testimony at public hearings that the information available on who receives services indicates underservice to certain age groups. Edwin Levine, interprogram planning evaluation supervisor with the Florida State Department of Health and Rehabilitative Services, testified that older persons do not receive the same kinds of funding levels under Title XX as other groups have had.[56] Mr. Levine estimated that approximately 8 percent of the State's Title XX funds goes to the aged and adult population. Although he did not provide information on the percent of the State's population that would be considered "adults," Mr. Levine estimated that approximately 16 percent of the population of the State of Florida is 65 or over.[57] Mr. Tsismanakis testified that a needs assessment conducted by the Department of Health and Rehabilitative Services in 1977 had shown that older persons were the age group most in need of expanded services—that there was an overrepresentation of older persons with unmet needs—but no increments in funding had been made in response to this assessment.[58]

Orlando Romero, executive director of the Denver Department of Social Services, testified that he has observed a deterioration in services to older persons because the child abuse and neglect and related workload is consuming most of the Title XX resources available:

> What has happened is the workload we have been given in terms of child abuse and neglect and the areas of families, this has taken almost all our resources, and what we have basically said is that we will pay as much attention as we possibly can to the protection of the aged in terms of exploitation or abuse. We have tried to give emphasis to nursing home placement. . ., and that's about the extent of it. The rest of the staff we have had has been pretty well delegated to the protection of children.[59]

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[55] Gilbert Murphy, testimony, *Hearing Before the U.S. Commission on Civil Rights, Denver, Colorado*, July 28–29, 1977, vol. I, pp. 90–91 (hereafter cited as *Denver Hearing*).

[56] Edwin Levine Testimony, *Miami Hearing*, p. 207.

[57] Ibid., p. 206.

[58] Tsismanakis Testimony, *Miami Hearing*, pp. 201–02.

[59] Orlando Romero Testimony, *Denver Hearing*, p. 106.

Ray Myrick, acting program director for the Public Services Administration of the Office of Human Development (HEW) in Denver testified that, while there was wide variation among the States, figures showing that in 1976 less than 10 percent of the Title XX money nationwide was utilized for services for older people were "probably fairly accurate, based on previous experience and looking at Title VI, one of the [Title XX program's] predecessors."[60]

Lucy Ellison, program director of the Public Services Administration, Office of Human Development, San Francisco, when asked which age groups experience lack of service or an abundance of service under Title XX, responded:

> There is a pretty good amount for children perhaps under 6 or 8 years of age in the form of child care, [but] not nearly enough, and there is a pretty good amount for services related to the infirm or the disabled, either in the form of home health services, homemaker chore services, or other kinds of activities. . . .[but] beyond that. . .there is a. . .wide deficiency or gap in terms of other kinds of services that could be made available that are not.[61]

Another Federal official with the Administration for Public Services in Seattle reported to Commission staff that most services in one of the States visited by Commission staff are aimed at children or families with children. He added that when funding limitations had forced the State to make conscious decisions about which people to serve under Title XX, it had "cut off" adults for the most part from receiving Title XX services.[62]

State Legislatures and Program Administrators' Policies and Practices

State legislatures and program administrators circumvent the Title XX planning process and establish age-specific priorities or policies and practices that result in converting Title XX into a categorical program for certain age groups.

One of the principal components of the Title XX social services program is the services program plan. No payment may be made to any State with respect to expenditures for any service to any individual unless, among other things, the State's services program planning meets the requirements set forth in the statute.[63] Such planning meets the requirements set forth in the statute if, for the purpose of assuring public participation in development of the plan: (1) the State establishes the beginning of the fiscal year of either the Federal Government or the State government as its services program year; (2) at least 90 days before the beginning of the State's services program year, the chief executive officer of the State or other such official publishes and makes generally available to the public a proposed comprehensive annual services program plan; (3) public comment on the plan is accepted for at least 45 days; and (4) a final comprehensive annual services program plan is developed and published, with an explanation of the differences, if any, between the proposed and final plans.[64] Among the information to be included in the proposed and final plans and to be made available for public comment are the objectives to be achieved under the program; the services to be provided; the categories of individuals to whom the services will be provided; and a description of the steps taken, or to be taken, to assure that the needs of all residents of, and all geographic areas in, the State were taken into account in the development of the plan.[65] Thus, the statute establishes a clear intent to assure public participation in the development of all phases of a State's social services program and an apparent presumption that such participation will contribute in some way toward shaping the final plan.

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[60] Ray Myrick Testimony, *Denver Hearing*, p. 115.

[61] Lucy Ellison Testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27–28, 1977, pp. 177–178 (hereafter cited as *San Francisco Hearing*).

[62] Richard McConnell, program supervisor, Public Services Administration, Office of Human Development Services, Department of Health, Education, and Welfare, interview in Seattle, Wash., May 5, 1977 (hereafter cited as McConnell Interview).

[63] 42 U.S.C. §1397a(a)(3)(A) (Supp. V 1975).

The Commission found that in many of the States included in the study, these provisions are not being complied with in a manner that would appear to meet the statute's intent. Priorities for expenditure of Title XX services, including age-specific priorities that have the effect of making Title XX an age categorical rather than a general purpose program, are being set by State legislatures and program administrators before a proposed plan is developed and public participation can be obtained and considered. As a result, the planning process has little real meaning because of pre-established priorities, and full consideration is not given to who should receive services.

One indication of the impact State legislatures have on the allocation of Title XX resources and of their ability to frustrate the intent of the services program planning process, was found in the State of Colorado's July 1, 1976, through June 30, 1977, *Comprehensive Annual Services Program Plan* (CASP). That plan states—

> The priorities for spending over eighty percent of the Title XX allocation are fixed by Colorado law or by the appropriations bill. Titles 14, 19 and 26 of C.R.S. 1973, as amended, contain legal mandates which have been incorporated into the service plan. Separate appropriations have been made for day care, foster care, and community centered boards, all of which have been incorporated into the Service Plan.
>
> The limited flexibility in setting priorities which results from the existence of legal mandates means that the State Department can make decisions about only a portion of the service program. The State Board of Social Services makes decisions to set priorities for that portion of the program not legally mandated. . .
>
> . . .The influence of the legislative budget review and appropriation process in establishing human services program policy is significant. The most effective form of citizen input and participation into the decision-

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[64] 42 U.S.C. §1397c (Supp. V 1975).

[65] 42 U.S.C. §1397c(2)(A), (B), (C), and (J) (Supp. V 1975).

> making process for Title XX is input to individual legislators and participation at the budget and human services committee meetings.[66]

David Ashmore, director of the Title XX social services program for the Colorado Department of Social Services, said:

> . . . .[A]bout 85 percent of the [State's Title XX] funds. . .are earmarked through various pieces of [State] legislation and various laws, which are very strong in Colorado for protective services for children. We have very weak laws in terms of protective services for adults; we rely on the probate codes, and we're pushing this. . . .[T]he law says you must provide these services to anyone who has a need for the service, on the one hand, and you don't have the laws or the mandates or the support for administering services, so where are you going to go? I think much of what is happening in Colorado is by default in terms of how many dollars we have and how many laws are implemented and the priorities, and the children and the families are getting the high priorities in Colorado.[67]

The age implications of State legislatures' setting age-specific priorities was also evident in Missouri, Washington, Illinois, Texas, Florida and California. In Missouri, Commission staff were told by the director of the State's Title XX social services program, and by an administrator of a local Title XX social services program, that action by the State legislature has had a strong influence on the structure of social services provided under Title XX. They said that the State legislature had passed a child abuse and neglect law in August 1975 that included strong penalties for non-compliance by administrators and others, and had designated the agency responsible for administering Title XX as the agency to implement the new legislation. No new State funds, however, were appropriated by the State legislature to implement the program, so the agency operated it with Title XX funds that had supported the provision of protective services to adults. Protective services for adults, which had been offered in every county, were eliminated in all but three cities in the State.[68] These Title XX administrators said that the agency could do this, because it is mandated by State law to provide a specific program of services to children but has only a general mandate to provide services to adults.[69] The director of the State agency designated to administer Title XX in Missouri and the member of his staff who developed the State's Title XX comprehensive annual services plan said that because the budget is developed before the planning cycle is completed, resource allocation is not done on the basis of the Title XX planning or needs assessment activities. They said that it is difficult, if not impossible, to relate needs assessments done as part of the planning process to the allocation of funds because of the legislative mandates that determine where funding will be directed regardless of needs assessment findings.[70]

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[66] State of Colorado, Department of Social Services, *Comprehensive Annual Services Program Plan: The Title XX Social Services Plan for the State of Colorado, July 1, 1976–June 30, 1977* (1976), pp. 75, 77. Day care is defined in the Colorado CASP (p. 40) as care of a child for a portion of a day, but less than 24 hours.

[67] David Ashmore Testimony, *Denver Hearing*, p. 109.

[68] Dwain Hovis, deputy director for social services, Division of Family Services, Department of Social Services, interview in Jefferson City, Mo., Apr. 7, 1977 (hereafter cited as Hovis Interview); Paul Nelson, director, St. Louis City Office, Division of Family Services, Department of Social Services, interview in St. Louis, Mo., Apr. 5, 1977 (hereafter cited as Nelson Interview).

[69] Ibid.

Commission staff were told by the director of the social services branch of the Texas Department of Public Welfare that the department is mandated by the Texas Family Code to provide protective services for children and by Federal legislation to provide at least three services to SSI recipients, and that the Department concentrates its resources on serving children and SSI recipients as a result of these mandates. He commented that 1978 would be the first year that the planning processes called for in the Title XX program would be fully implemented because the State legislature, which meets on a biennial basis, had approved the 1975 and 1976 budgets for social services, including appropriation of funds for specific services and activities, prior to implementation of the Title XX program. He said that because of this action, few changes in services could be made during development of the Title XX plan for each of these years.[71]

Similarly, in Illinois, a staff member of the office responsible for the Title XX plan said that during the development of the plans for both the first and second years of the program's operation, there was public participation, but that there could be little change in either year's plan because budget decisions for the State had already been made.[72] The special assistant to the Governor for social services in the State said that priorities regarding what services will be provided under Title XX and to whom, are established in the budget process, which had preceded the Title XX program planning process. He added that the Governor's office is trying to create a situation where the agencies' budgets and the Title XX plan will be submitted at the same time to the Governor's office, after which a comprehensive plan would be sent to the legislature.[73]

Staff learned that in California, 10 of the 24 social services provided in the State are required by State law and were in existence at the time the Title XX program was implemented, and further that a number of these are age-specific. The 10 services are: information and referral; protective services for children; protective services for adults; out-of-home care services for children; out-of-home care services for adults; child day care services; health related services; family planning; in-home supportive services for aged, blind, and disabled persons; and employment-related services for AFDC recipients.[74]

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[70] Hovis Interview.

[71] Burt Raiford, director, Social Services Branch, Department of Public Welfare, interview in Austin, Tex., Apr. 27, 1977.

[72] Mary Ann Eckert, staff assistant to the chief, Bureau of Social Services, Department of Public Aid, interview in Springfield, Ill., May 18, 1977 (hereafter cited as Eckert Interview).

[73] Tom Berkshire, special assistant to the Governor of Illinois for social services, interview in Chicago, Ill., May 20, 1977 (hereafter cited as Berkshire Interview).

[74] State of California, *Comprehensive Annual Services Program Plan—July 1, 1977—June 30, 1978,* (1977), pp. 8–9.

Edwin Levine of the Florida Department of Health and Rehabilitative Services testified that in Florida the allocation of dollars in the proposed Title XX plan, including services to specific groups, is based on the recommended budget that the Governor submits to the State legislature. Mr. Levine said that the governing document for allocation of resources under the Title XX plan is the final appropriations act of the legislature. He stated upon questioning that the department, which was holding public meetings around the State on the proposed Title XX plan at the time the legislature was considering the appropriations bill, did not make any specific requests for increases or decreases in funding that had a Title XX component while the legislature was in session.[75]

The importance of State legislative action was also noted in Washington State. A regional planner for Title XX in the Washington Department of Social and Health Services said that the State legislature had mandated protective and foster care services for children and that this mandate had had a major impact on the allocation of resources under the Title XX program.[76] The chief of the department's Office of Family, Children, and Adult Services told Commission staff that the State legislature also mandates adoption services, juvenile delinquency prevention, and congregate care. He said that while the department has operated an active adult protective services program, legislation is needed to put adult protective services on a par with child protective services. Such legislation, he said, had been introduced that year, but its chances for passage were rated as only fair.[77]

The Commission found that in addition to directly influencing the age groups to whom Title XX services are provided, enactment of age-specific State legislation can also influence who receives Title XX services by affecting the allocation of staff to provide services to adults and children.

Missouri's proposed *Comprehensive Annual Services Program Plan* for July 1, 1977, to June 30, 1978, states: "The primary method of implementing services authorized by these [State] laws is by utilizing State appropriations to employ social service workers."[78]

Commission staff were told that before the State child abuse legislation was enacted, the Missouri Department of Social Services had distributed staff positions for provision of direct services to the city and county welfare offices according to their proportion of the State's aid to families with dependent children and supplemental security income populations. After enactment of the child abuse law, staff who had been providing direct services to adults were either transferred to the section of the department responsible for purchased services, or were made responsible for providing services in connection with child abuse. Social workers in the department had objected to this change because they believed that unless direct services were available in each county welfare office to adults, the elderly would be neglected.[79]

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[75] Levine Testimony, *Miami Hearing*, p. 204.

[76] Patricia Solberg, Title XX planner, Region 4, Department of Social and Health Services, interview in Seattle, Wash., Apr. 25, 1977 (hereafter cited as Solberg Interview).

[77] William Quick, chief, Office of Family, Children and Adult Services, Bureau of Social Services, Community Services Division, Department of Social and Health Services, interview in Olympia, Wash., May 2–3, 1977 (hereafter cited as Quick Interview).

[78] State of Missouri, Department of Social Services, Missouri Division of Family Services, *Proposed Comprehensive Annual Social Services Program Plan, Program Year July 1, 1977, to June 30, 1978* (1977), p. 9.

Shirley Harris, social services administration supervisor for the Adams County, Colorado, Department of Social Services, testified that the State legislature's priority on child abuse and foster care has resulted in discrimination against older persons, whom she defined as persons 50 or over. Ms. Harris said that the ratio of staff working with adults to staff working with children in her department was set as 1 to 8, and that this priority resulted, in part, because of the mandated programs.[80]

The Commission found that Title XX program administrators also establish policies and practices that result in converting Title XX, or certain of the services provided under the program, into an age-specific program. Some limitations on participation by certain age groups have been a consequence of States' selection of the categories of individuals who will be provided services.

As stated earlier, the statute sets forth only two requirements regarding the categories of eligible persons States must elect to serve. First, 50 percent of the expenditures for which the Federal Government makes payment to a State for Title XX social services must be spent for services to individuals who are eligible for or receiving AFDC or whose needs are taken into account in determining the needs of these individuals; who are receiving or eligible for SSI benefits or State supplementary payments or whose income and resources are taken into account in determining the amount of benefits; or who are eligible for Medicaid.[81] Second, the State's comprehensive annual services program plan must set forth the services to be provided under the program, including at least three types of services to SSI recipients in need of such services.[82]

Except for these requirements, States may provide any services to any categories of individuals as long as they identify the services and categories of persons to receive them in the plan. If, for example, administrators elect to provide certain services only to recipients of AFDC, as was done for receipt of employment services in California,[83] they effectively limit receipt of those services to persons in the age groups who comprise the State's AFDC recipient population. Assuming that persons receiving AFDC in a State are similar in makeup to persons receiving AFDC in all States, selection of only AFDC recipients for services would, for the most part, limit receipt of those services almost exclusively to women, who constitute almost 90 percent of adult recipients of AFDC nationally, and further, to women between the ages of 19 and 40, who make up 75 percent of adult women receiving AFDC.[84]

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[79] Hovis Interview; Nelson Interview.

[80] Shirley Harris Testimony, *Denver Hearing*, p. 107.

[81] 42 U.S.C. §1397a(a)(4) (Supp. V 1975).

[82] 42 U.S.C. §1397c(2)(B) (Supp. V 1975).

[83] U.S., Department of Health, Education, and Welfare, Office of the Assistant Secretary for Planning and Evaluation, *Technical Notes: Summaries and Characteristics of States Title XX Social Services Plans for Fiscal Year 1977*, p. 27.

Similarly, limiting receipt of some services to SSI recipients, if a State's recipient population compared with national data, would create a recipient population almost exclusively comprised of persons 50 or over, since, according to the Social Security Administration of the Department of Health, Education, and Welfare, persons 50 or over were 78 percent of adults receiving federally-administered SSI payments (including federally-administered State supplements) in December 1976. (Slightly over 50 percent of the adults receiving SSI were receiving benefits as "aged" persons, with the remaining adults receiving benefits based on blindness or disability. Children who were blind or disabled were less than 4 percent of all SSI recipients during this same period.)[85]

Other restrictions on receipt of services by specific age groups, however, have resulted from the establishment by State or local administrators of specific age limitations on receipt of services, or selection of specific age groups for receipt of services. For example, the *Plan for Public Aid Services* for the Illinois Department of Public Aid, published in April 1976, included age requirements in the definitions of some of the services offered by the Department. These services, and the age requirements applied to them, were:

- **day care for children under age 13;**
- **education and training services for persons 18 through64;**
- **family planning for persons 15 through 44;**
- **foster care for children under 18;**
- **services to unmarried parents for females 15 to 39; and**
- **services to WIN participants for persons 16 through 64.**[86]

These same services were identified in the State's final comprehensive annual services program plan for October 1, 1975, to June 30, 1976, and in the proposed plan for July 1, 1977, to June 30, 1978, but the age limitations were not included.[87] Thus, although this information was not included in the proposed Title XX plan made available to the public for review and comment, the agency administering the Title XX program was evidently applying age-specific restrictions to the Title XX-funded services.

In other States visited, service definitions were generally not as age-specific, but plans did identify certain services as being for children, youth, the elderly, etc. Washington State's CASP for fiscal year 1977 states that adult day care services are for "aged people who do not require 24-hour institutional care"[88] and that child day care is for children under 15.[89] Maine's Title XX CASP covering the period October 1, 1975, through June 30, 1976, provides for "camperships for children" and "meals for the elderly" and "recreation and socialization for the elderly."[90]

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[84] U.S., Department of Health, Education, and Welfare, National Center for Social Statistics, unpublished data for May 1975.

[85] U.S., Department of Health, Education, and Welfare, Social Security Administration, data provided by Virginia Kirschbaum, disability specialist, Division of Rehabilitation Programs, Bureau of Disability Insurance, SSA.

[86] State of Illinois, Department of Public Aid, *Illinois Welfare and Rehabilitation Services Plan, Volume 2: Plan for Public Aid Services, Fiscal Years 1977–1979* (1976), pp. 11–31.

[87] State of Illinois, Illinois Department of Public Aid, *The Comprehensive Annual Services Plan for Illinois for the Program Year October 1, 1975 through June 30, 1977* (1975), pp. 21–46, and State of Illinois, Illinois Department of Public Aid, *Proposed State of Illinois Comprehensive Annual Services Plan for Program Year July 30, 1977, through June 30, 1978* (1977), pp. 23–54.

Commission staff were also told by some State and local administrators that even when services are not specifically defined as being for certain age groups, they emphasize certain age groups in the operation of programs. For example, the acting director of the Maine Bureau of Resource Development said that emphasis in provision of alcoholism services is placed on persons 50 or over, that emphasis in day care for children is on those 6 or under, and that emphasis in services to the mentally ill is on deinstitutionalized adults 40 or over.[91] The Title XX planner for region 4 in the State of Washington said that child protective services, child foster care, adoption, child day care, juvenile delinquency prevention, and services to the developmentally disabled were available to persons 18 or under, adult day care services were available to persons 18 or over, and chore services, placement services, alcoholism services, health support services, and information and referral services were available to persons of all ages.[92]

By making these distinctions on the basis of age in the conditions under which persons are eligible for services and restricting certain services to particular age groups, administrators of Title XX programs influence, without apparent justification, the age composition of persons able to participate in the programs.

Reliance on Historical Patterns

The Commission found that in the sites visited as part of the study, Title XX program administrators often relied on historical patterns of allocation of social services resources to decide how resources should be allocated under the Title XX social services program, and that in some cases, age discrimination resulted because those historical patterns themselves had not distributed resources in an equitable manner to different age groups.

The Title XX program, as indicated in the program description, replaced the social services programs that had been authorized under Titles IV–A and VI of the Social Security Act for recipients of aid to families with dependent children and recipients of aid to the aged, blind, and disabled. These programs of social services had been in operation, with modification, since 1956, when the Congress authorized provision of services by staff of State welfare agencies to applicants for, and recipients of, cash assistance for the above named groups. These services were considered an administrative cost of the cash assistance program for which the Federal Government matched 50 percent of States' expenditures.[93]

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[88] State of Washington, Department of Social and Health Services, *Final Comprehensive Annual Social Services Program Plan for the State of Washington, FY 1977* (1976), p. 122.

[89] Ibid., p. 101.

[90] State of Maine, Department of Human Services, Bureau of Resource Development, *State Plan, Social Services Act of 1974, Title XX* (1975), pp. 19 and 21 (hereafter cited as *Maine CASP*).

[91] Dan Wilson, acting director, Bureau of Resource Development, Maine Department of Human Services, interview in Augusta, Me., May 24, 1977 (hereafter cited as Wilson Interview).

[92] Solberg Interview.

In 1962, amendments to the Social Security Act expanded the availability of funds to cover services purchased by the State agencies from other public or nonprofit private agencies, raised the Federal share of States' social services expenditures to 75 percent, and authorized reimbursement for expenditures for services to former or potential applicants for, or recipients of, cash assistance as well as for previously authorized expenditures for services to applicants for and recipients of cash assistance.[94] Also in 1962, amendments were enacted that enabled States, if they chose, to administer a single program of aid to the aged, blind, or disabled and medical assistance for the aged, rather than separate programs.[95]

The emphasis on social services had increased in both the AFDC program and in the cash programs for the aged, blind, and disabled during this developmental period. The specificity of the program requirements for families of needy children and for the aged, blind, and disabled, was, however, quite different. Amendments to the AFDC program in 1962 substituted the language "aid to families with dependent children" for "aid to dependent children" and required that States provide for a program for child welfare services and family services.[96] Family services were defined as—

> services to a family or any member thereof for the purpose of preserving, rehabilitating, reuniting, or strengthening the family, and such other services as will assist members of a family to attain or retain capability for the maximum self-support and personal independence,. . .[97] Child welfare services were defined as—

> public social services which supplement, or substitute for, parental care and supervision for the purpose of (1) preventing or remedying, or assisting in the solution of problems which result in, the neglect, abuse, exploitation, or delinquency of children, (2) protecting and caring for homeless, dependent, or neglected children, (3) protecting and promoting the welfare of children of working mothers, and (4) otherwise protecting and promoting the welfare of children, including the strengthening of their own homes where possible or, where needed, the provision of adequate care of children away from their homes in foster family homes or day-care or other child-care facilities.[98]

In 1968, amendments to Title IV made the services to be provided even more specific. The amendments mandated that, to receive Federal reimbursement for social services, States had to provide programs for preventing or reducing the incidence of births out of wedlock, reporting incidents of neglect, abuse, or exploitation to the appropriate authorities, establishing paternity and securing child support; a work incentive program; foster care; and day care.[99]

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[93] Social Security Amendments of 1956, ch. 836, Title III, §300, 70 Stat. 846.

[94] Public Welfare Amendments of 1962, Pub. L. No. 87-543, Title I, §104(c)(1), 76 Stat. 172.

[95] Public Welfare Amendments of 1962, Pub. L. No. 87-543, 76 Stat. 172, 197.

[96] Public Welfare Amendments of 1962, Pub. L. No. 87-543, 76 Stat. 172, 185.

[97] 42 U.S.C. §606(d)(1970).

[98] 42 U.S.C §625(1970).

The 1962 amendments to the old age assistance, aid to the blind, and aid to the disabled programs required only that a State, in order to qualify for administrative funds for its aged, blind, and disabled programs, must provide in its State plan that—

> the State agency shall make available to applicants for or recipients of old-age assistance under such State plan at least those services to help them attain or retain capability for self-care which are prescribed by the Secretary.[100]

By 1970, the only services set forth in Federal regulations as mandatory services for the aged, blind and disabled were information and referral services, protective services, services to enable persons to remain in or return to their own homes or communities, services to meet health needs, and self-support services for the handicapped.[101]

This brief chronology of the growth of social services under the programs points up the contrasts, particularly until 1968, between the services program requirements for AFDC and the requirements for the aged, blind, and disabled. The services program established for AFDC recipients and eligibles was more explicit with regard to what was to be provided than was the program for the aged, blind, and disabled. Services were specified for AFDC recipients earlier in time than were mandatory services for recipients of aid to the aged, blind, and disabled.

All States provided services under Title IV–A of the act, but were slower to provide services to the aged, blind, and disabled. At the beginning of 1967, 43 States were providing social services to adults; however, during that year, four States withdrew from the program, three (Arkansas, Connecticut, and Louisiana) because they were unable to meet the requirement passed in July 1967 that States provide a full scope of services for adults, and one (Oregon) to devote greater effort to the AFDC program.[102]

By the end of 1971, all jurisdictions but one were providing social services to adults. Expenditures for services to persons in the adult categories, however, were much lower than for services to recipients of aid to families with dependent children.[103] This pattern continued until Title XX was implemented, as is shown in table 1.2.

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[99] Social Security Amendments of 1967, Pub. L. No. 90–248, 81 Stat. 821, 914.

[100] Public Welfare Amendments of 1962, Pub. L. No. 87–543, 76 Stat. 172, 179.

[101] 45 C.F.R. §§222.40–222.47 (1970).

[102] U.S., Congress, Senate, Special Committee on Aging, *Developments in Aging, 1967,* 90th Cong., 2d sess., 1968, S. Rept. 1098, p. 272.

[103] U.S., Congress, Senate, Special Committee on Aging, *Developments in Aging, 1971 and January-March 1972,* 92d Cong., 2d sess., 1972, S. Rept. 92–184, p. 259.

Table 1.2
Unadjusted Social Services Expenditures, Federal Share, Fiscal Years 1971-1975

Fiscal Year	Title IV-A Expenditures (AFDC) (in thousands)	Titles I, X, XIV & XVI (Title VI)[a] Expenditures Aged, Blind, & Disabled (in thousands)	Total Expenditures (in thousands)
1971	$563,104	$141,295	$704,399
1972	1,263,359	324,915	1,588,274
1973	1,497,142	381,420	1,877,562
1974	1,197,713	433,667	1,631,380
1975	1,283,619	669,886	1,953,505

[a] The Social Services provisions of Titles I, X, XIV, and XVI of the Social Security Act became Title VI of the Act in 1974.
Source: U.S., Department of Health, Education, and Welfare, Administration for Public Services, Unpublished Data.

This pattern of lower expenditures for non-AFDC recipients appears to have continued under the Title XX program. Most of the services that had been mandated under the social services provisions of Title IV–A were the services for which States estimated that their fiscal year 1977 expenditures would be the greatest. The services and the percentage of the total budget that States estimated that they would spend for those services are shown in table 1.3.

A recent report of the Urban Institute on the first year's experience with implementation of the Title XX program confirms that there has been little change from the previous programs in the persons served and services provided under Title XX. The report concluded that "no significant changes were observed in the types of services funded by Title XX or the demographic characteristics of service recipients."[104]

Witnesses at public hearings and persons interviewed in the field study told the Commission that priorities established under the programs that preceded Title XX had been followed under the Title XX program, and that this had affected the age distribution of Title XX resources.

Orlando Romero, executive director of the Denver Department of Social Services, testified that the amount of money available to the State had been encumbered almost from the very outset of the program, and that priorities had been established on the basis of historical

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[104] Turem, *Implementation of Title XX*, p. 6.

Table 1.3
Estimated Title XX Expenditures by Type of Service, Fiscal Year 1977

Type of Service	FY 1977 Estimated Expenditures (in millions)	Percent of Total Budget
Child Day Care	$742.8	24.1%
Home Based Services	445.5	13.2
Substitute Care for Children	237.6	8.2
Protective Services for Children	241.3	8.1
Health and Mental Health Services	124.2	4.4

Source: U.S., Department of Health, Education, and Welfare, Office of the Assistant Secretary for Planning and Evaluation, *Technical Notes: Summaries and Characteristics of States' Title XX Social Services Plans for Fiscal Year 1977* (1977), p. vi.

patterns, with the needs of children and families taking priority.[105] David Ashmore, director of the Title XX program for the Colorado Department of Social Services, supported this statement. He pointed out that the State was already "locked in" when Title XX was introduced, because commitments had already been made to the people who were being served to continue their services. Because Colorado was spending at the ceiling of its Federal allotment it could not provide additional services without cutting back on services already being provided.[106]

Joe Lain, chief of the Social Services Planning Branch, Social Services Division, California Department of Health, when asked how service priorities had been established in California, said:

> California at the point the Title XX (program) was enacted had a fairly full range of social services programs already in place which were for the most part mandated by State law. We also. . .were fully utilizing our allocation of Title XX funds. So that we did not have a great deal of flexibility in terms of making changes that seemed to be promised by the enactment of Title XX.[107]

Edwin Schulz, Acting Regional Director for the Administration for Public Services of the Department of Health,Education, and Welfare in Atlanta, testified that 8 years ago—1969—only five of the eight States in his region had a program of adult social services for the aged, blind, or disabled, indicating the slower pace with which adult services had developed.[108] Edwin Levine, of the Florida Department of Health and Rehabilitative Services, conceded that the present pattern for the distribution of funds in the State is an historical pattern and said that "the historical pattern truly does not give to the aged in the State of Florida the same kind of funding levels that other groups have had that were there 'first'."[109] Mr. Levine stated that the issue facing the State of Florida was where to reduce expenditures, but agreed that the State should not base choices and priorities on historical patterns.[110]

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[105] Romero Testimony, *Denver Hearing*, p. 106.
[106] Ashmore Testimony, *Denver Hearing*, p. 108.
[107] Joe Lain Testimony, *San Francisco Hearing*, p. 182.

Another Title XX program administrator indicated that the high priority in his State on serving children results from the historical emphasis of social services on children, from a strong children's lobby, and from the fact that "the aging are pretty much newcomers" to the social services area.[111]

The fact that older persons were not served adequately under the social services programs that preceded Title XX was also discussed by Margaret Jacks, former director of the Office of Aging and Adult Services in the Florida Department of Health and Rehabilitative Services. Ms. Jacks testified that "working with older people was never considered very important." She went on to say that the department had had weighted caseloads, wherein the number of staff assigned to old age assistance, AFDC, or child welfare units was based on ratios of one for each old age assistance recipient, two and a half for each AFDC recipient, and eight for each child welfare recipient. Ms. Jacks stated that, as a result, there has never been a staff allocated in public welfare to serve the aged adequately in terms of providing social services, and there has been little or no recognition of the need for time and skill in working with older people. She noted further that this lack of recognition has persisted under the Title XX program.[112]

Another manifestation of the reliance on historical patterns was uncovered in the structure or system followed in the delivery of services. Title XX administrators stated that a factor in their decisions regarding what services to provide was what service providers were already operating in the community and what services they were equipped to provide. The regional administrator for the Purchase of Service Unit in the Missouri Department of Social Services in St. Louis identified two factors that had influenced the provision of social services during the first year of the Title XX program: where and what local funds were available for matching since the State did not provide enough money for matching; and what earlier contracts existed with providers. She said that with regard to providers, some are selected because they have had contracts in the past and have client groups in the community that they are already serving.[113] Another member of the staff noted that decisions on where services will be located in the community are in large part the result of the "clout" that providers have.[114]

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[108] Edwin Schultz Testimony, *Miami Hearing*, p. 209.

[109] Levine Testimony, *Miami Hearing*, p. 207.

[110] Ibid.

[111] Berkshire Interview.

[112] Margaret Jacks Testimony, *Miami Hearing*, p. 219.

[113] Phyllis Reser, regional administrator, Purchase of Service Unit, Division of Family Services,

In Maine the director of the Title XX program said that publicity with regard to the Title XX planning process had been limited mainly to provider groups.[115] Although he did not comment on whether the provider groups had argued that the State should continue the existing contracts and continue to provide the services the providers were already offering or able to offer, it seems likely that they would take such a position. A regional office official of the Public Services Administration of the Department of Health, Education, and Welfare told Commission staff that providers ensure their continuity by pressuring State legislators and the Governor, and said that providers and interest groups tend to dominate public hearings on the Title XX plan.[116]

Thus, because State and local Title XX program administrators, in deciding on what services they will offer, follow historical patterns that have been oriented to families with children and base their choice of services on what providers have been associated with the program, certain age groups continue to go without their fair share of services.

Contractors that Place Age Limitations on Services

Agencies administering the Title XX social services program may provide services directly by using their own staff and facilities, or they may enter into contractual arrangements with other agencies and organizations to provide some or all of the social services offered under the Title XX comprehensive annual services program plan.[117] Although the extent to which services are purchased from other public and private nonprofit agencies varies by State, the use of purchased services has generally increased since Title XX was implemented.[118] The Department of Health, Education, and Welfare reported that, based on information provided by States for the period between April and June of 1976, State agencies administering Title XX social services purchased nearly 50 percent of all services from other public and private agencies.[119]

The Commission found that contractor agencies frequently limit receipt of some or all of their services to persons within particular age ranges. For example, at one site in the field study, services were purchased from 13 organizations, nine of which had age requirements for participation in their programs.[120] These agencies and the age restrictions they placed on participation are presented in table 1.4.

Department of Social Services, interview in St. Louis, Mo., Apr. 8, 1977 (hereafter cited as Reser Interview).

[114] Anna Guber, social services supervisor I, Purchase of Service Unit, Division of Family Services, Department of Social Services, interview in St. Louis, Mo., Apr. 5, 1977 (hereafter cited as Guber Interview).

[115] Wilson Interview.

[116] McConnell Interview.

[117] 42 U.S.C. §1397c(2)(G) (Supp. V 1975); 42 Fed. Reg. 5842, 5862 (1977) (to be codified in 45 C.F.R. §228.70).

[118] Turem, *Implementation of Title XX*, p. 70.

[119] *Social Services U.S.A. April–June 1976*, p. 70.

[120] James Washeck, social services supervisor II, Purchase of Service Unit—Eastern Region, Division of Family Services, Department of Social Services, interview in St. Louis, Mo., Apr. 5–6, 1977 (hereafter cited as Washeck Interview).

Table 1.4

Organizations Providing Purchased Services Under Title XX in One Study Site and Age Restrictions on Participation

Type of Agency/Service[a]	Age Restrictions[b]
Area Agency on Aging—provides homemaker, chore, transportation, home delivered and congregate meals, and social skills services	60 or over
Housing Authority—provides homemaker, chore, transportation, home delivered and congregate meals, and social skills services	60 or over or 18 or over if handicapped or disabled
Child Day Care Organizations and Public Schools—day care for children	ages differ by contract, but children range from 2 to 12
City Hospital—evaluation, diagnosis, and testing for children up to age 5 who have been referred through health clinics. For children 3 or over, counseling parents is included	5 or under
Public School (K-12)—counseling by school social workers for elementary school children	kindergarten through 8th grade
Child Care Association—residential treatment for homeless, neglected and dependent children who have gone through the juvenile courts	children
Older American Transportation Service (OATS)	no specific restriction, but name suggests age requirements
Junior Kindergarten	preschool children
Preschool	to school age

Source: [a] State of Missouri, Department of Social Services, Missouri Division of Family Services, *Purchase of Services, Eastern Region: Monthly Report Beginning March 1, 1977* (1977).

[b] James Washeck, Social Services Supervisor II, Purchase of Service Unit—Eastern Region, Division of Family Services, Department of Social Services, interview in St. Louis, Mo., Apr. 5-6, 1977.

In some instances, these contractors impose age requirements because they are authorized by Federal legislation to serve specific groups. This would be true, for example, of the area agency on aging with whom the Title XX agency in the site discussed above contracted. The authority under which the agency is established, the Older Americans Act, authorizes area agencies on aging to act on behalf of older persons.[121] In other instances, however, the contractor agencies had established age requirements without any Federal authorization. At the site discussed above, all of the agencies contracted with for the provision of child day care services set age requirements. Age requirements for day care were extremely varied. For example, the age requirements for children who would be served included those 6–14, 5–12, 3–6, 2–6, 3–5, 6–11, 3–11, and 2 1/2–6.[122] No explanation was given for these age requirements or why they varied among the different centers. At this same site, the Title XX agency had entered into a contract with the public school system to provide counseling. It was originally developed to serve persons from kindergarten through 12th grade, but was modified to serve kindergarten through 8th grade students when the schools could not make as many referrals as had been specified in the contract and wanted to concentrate their efforts on a narrower age range.[123]

Another example of contracting with agencies that place age limitations on participation in their programs was found in Maine's CASP for the period October 1, 1975, to June 30, 1976. The plan includes a section on "other agencies providing human services in Maine," the types of agencies with whom the Title XX agency would contract for purchased services. Many of these agencies, which are too numerous to detail, had age requirements for participation in their services, including: drug abuse services for persons 16 to 25; an educational enrichment program for disadvantaged youth 18 or older; speech and hearing evaluations for children under 18; special education for children 6–15; special education for children 5–19; residential psychiatric treatment for boys 5–12 and adolescents; residential care for children 4–12; a well-aging clinic for adults 50 or over; a senior citizens center for persons 60 or over; YMCA residential facilities for women 18–30; dental care for children under 18; a home for exceptional adults 18–50; and child day care programs with varying age requirements.[124]

These examples, and the fact that almost half of all services provided under the Title XX program are purchased services, suggest that if Title XX agencies continue to contract with agencies and organizations that place age limitations on their services without authorization to do so, persons of a variety of ages will be unnecessarily excluded from participating in certain services or in the entire program, regardless of their need, because of their age.

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[121] 42 U.S.C. §§3021–3029 (Supp. V 1975).

[122] St. Louis, Missouri, Division of Family Services, *Guide to Title XX Services for Fiscal Years 1976–1977* (1976), pp. 16–18.

[123] Guber Interview.

[124] *Maine CASP,* Appendix of Other Agencies Providing Services in Maine.

Outreach and Referral Activities

For purposes of the study, the Commission defined outreach as a process through which potential participants are notified about available services or benefits and how to use them, and are provided access to them. Outreach has been shown to be important because of its effect on who participates in a program. Without outreach, or with limited outreach, persons otherwise eligible for a program may not apply for services or benefits because they do not know about them. With outreach, programs may be better able to ensure that all eligible and interested persons have an opportunity to participate, or may be able to target persons who are underrepresented in a program's service population.

Commission staff were told in several of the sites visited during the field study and the public hearings that certain age groups have greater need for outreach than others, and that without outreach, these persons are not in a position to take advantage of the social services available.

The chief of the Office of Family Services in the Washington Department of Social and Health Services told Commission staff that he did not think the outreach program was reaching all persons eligible for Title XX services, and indicated that he believed this was particularly true of the aged because they are more isolated socially, have problems getting to service sites, and are more hesitant to ask for help; of low-income people, because they are not well educated and not as aware generally; and of infants and children, because they are dependent on parents who may themselves be the problem.[125]

In Missouri, Commission staff were told by the administrator of a purchase of service unit that there is a large population consisting of older persons and young adults that is not aware of the services that are available.[126] Another member of the staff of that agency said that he does not believe that outreach is reaching older persons, and that older persons seem to have more difficulty understanding and acting on information provided them.[127]

An administrator of the Title XX program in Maine said that it is difficult to reach people living a long distance from service centers who lack transportation services.[128]

The age group most frequently mentioned as the group that would most likely be affected by a lack of transportation was older persons. E. Bentley Lipscomb, program director of aging and adult services of the Florida Department of Health and Rehabilitative Services, testified:

> . . .[older persons are] very dependent upon some kind of transportation to get to existing services. You can have all of the services in the world, but this particular group is most vulnerable, in terms of not being able to take advantage of the network of services that are available in the community, simply because

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[125] Quick Interview.

[126] Reser Interview.

[127] Washeck Interview.

[128] Wilson Interview.

> they cannot move from point A to point B to receive those services.[129]

Shirley Harris, social services administration supervisor for the Adams County, Colorado, Department of Social Services, testified that limited transportation and the location of offices designated to serve older persons present barriers:

> We do not have [a Social Security district office providing supplemental security income benefits]. . .located in the county, so transportation difficulties that would not be as outstanding in Denver, for example, exist. How to get downtown or for a person who's older but still drives, just driving downtown, those problems have to be worked out, often without the assistance of the department of social services. One, because no funds are available to subsidize a trip downtown to the office, but also because we never come in contact [with the persons who need this assistance] even if we would be inclined to give local funds to assist in that service.[130]

Finally, Commission staff were told that persons without contact with the cash public assistance programs are particularly difficult to reach. Lucy Ellison of the Public Services Administration's San Francisco office testified:

> . . .usually the major access into our office [is] through the categorical aids of public assistance and this has been in the past and I am not of the impression that perhaps, except maybe for children, that this is changed dramatically. So that you have a situation in which there is a group here who is not necessarily being served consistently by anyone, in terms of the money payment program. They are not known to the agency, and I think their access to services is made that much more difficult because of the lack of affiliation with any particular delivery agency.[131]

Ms. Ellison indicated that this lack of contact with the public assistance program because of nonparticipation in the Federal-State cash assistance program is a problem faced by persons between 21 and 64.[132] Other administrators indicated, however, that this also affected receipt of services by persons 65 or older, because they receive cash assistance through the Social Security Administration rather than the welfare departments, which also administer Title XX.

Eligibility for cash assistance for aged, blind, and disabled persons under the SSI program has been determined in the district offices of the Social Security Administration since 1974 when the SSI program was implemented.[133] In those States that supplement the Federal SSI payment, persons may have to contact the department of public welfare to be determined eligible for the State supplement. In other cases, however, States have elected to have the Social Security Administration administer the State supplement along with the Federal payment.[134] Because older persons do not or are unlikely to have any contact with the department of public welfare unless they receive a State supplement in a State where the Department of Public Welfare administers the State payment, they may not be aware of assistance available to them through social services, food stamps, and, in some cases, Medicaid.

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[129] E. Bentley Lipscomb Testimony, *Miami Hearing*, p. 223.

[130] Harris Testimony, *Denver Hearing*, p. 119.

[131] Ellison Testimony, *San Francisco Hearing*, pp. 178–79.

[132] Ibid., p. 178.

[133] 42 U.S.C. §1381 (Supp. V 1975).

The problems this creates when little or no outreach is available from Title XX agencies were discussed by many persons during the field study and in the public hearings.

A local Title XX administrator in Washington State said that aged SSI clients might be the hardest to reach because of isolation, and that requests from low-income older persons for services had decreased after they had switched to the supplemental security income program. She did not know what information and referral was being provided to these individuals by the Social Security Administration, but stated that "we just don't see those old people as often."[135]

A State Title XX administrator in Missouri said that referrals of SSI eligibles to social services are dependent on the Social Security offices. He noted that the SSI population is decreasing in the State, and said that that may indicate either poor outreach by the Social Security Administration, or increased reluctance on the part of older persons to enter into the program. One particular problem he pointed out was that Social Security offices are not in every county, and that as a result older people may have to travel some distance to be determined eligible for SSI and receive information about social services.[136]

Lucy Ellison, with the Administration for Public Services of the Department of Health, Education, and Welfare in San Francisco, agreed that federalizing cash assistance to the aged, the blind, and the disabled and moving them out of the State public welfare system has created problems for SSI recipients in receiving Title XX services and said that "part of the problem is related to the inherent gap that was left by the legislation."[137] Joe Lain, chief of the Social Services Planning Branch of the Division of Social Services, California Department of Health and formerly chief of the Adult Services Division, concurred with this statement, saying:

> . . .the impact of H.R. 1 [the legislation enacting the supplemental security income program] in terms of the SSI population has been fairly large in terms of the reduction in the number of referrals for social services. . . .[138]

The director of the income maintenance unit in a local department of public welfare, responded to a question about whether persons eligible for cash assistance under the SSI program are told about the potential benefits under Medicaid, food stamps, and Title XX social services programs, by saying that individuals have to make an application themselves for benefits, and that the Social Security district office does not generally refer applicants to the social services program. He also said that although he recognized that persons were not being referred for social services by the Social Security Administration, his office was not taking any steps to bring these persons into the social services system.[139] Another program administrator at the site confirmed this statement and reported that the Social Security Administration rarely refers persons eligible for SSI to the agency providing social services. She said that most referrals of older persons are the result of provider efforts.[140]

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[134] s1616(a).

[135] Shirley Johnson, social service supervisor II, Kent ESSO, Region 4, Department of Social and Health Services, interview in Seattle, Wash., Apr. 26 and 28, 1977 (hereafter cited as Johnson Interview).

[136] Hovis Interview.

[137] Ellison Testimony, *San Francisco Hearing*, pp. 191–192.

[138] Lain Testimony, *San Francisco Hearing*, p. 192.

At another site, a regional official in the Office of Human Development of the Department of Health, Education, and Welfare reported to Commission staff that strong antagonism had developed between staff at the Social Security district office and social workers in one State when the SSI program had first gone into effect. Social Security staff had referred SSI recipients to the State for services without knowing whether the types of services needed were actually available. As a result, the Social Security staff were criticized by the State's social service workers, and reduced their referrals to the State agency administering Title XX.[141]

Despite this recognition by administrators that some age groups have unique problems in obtaining information needed to take advantage of available services, the Commission determined that, in fact, little outreach was being conducted, and few attempts were being made to address the problems unique to certain age groups, with the exception of those for children.

Staff were told by a State-level administrator in Illinois that there was no formal outreach or information and referral, other than for child abuse, because of limited resources in the State and a concern about creating a demand for services that could not be met. The administrator said that the effect that limited outreach may have on certain age groups is suggested by data on recipients of services by age. The percent of recipients by age was:

0–20—57 percent

21–35—26 percent

36–45—6.9 percent

41–65—5.6 percent

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[139] Lloyd Conley, director, Income Maintenance Unit, Division of Family Services, Department of Social Services, interview in St. Louis, Mo. Apr. 12, 1977 (hereafter cited as Conley Interview).

[140] Reser Interview.

[141] McConnell Interview.

66 or over—2.9 percent[142]

Another administrator at this site stated that lack of an information and referral system presents barriers to getting into the overall social services system, and that these barriers particularly affect older persons because they are not receiving cash assistance and social services from the same agency and have mobility problems.[143]

The Title XX coordinator for the Texas Department of Public Welfare said that the State has no formal outreach system, and that the general approach to outreach has been to have special public information efforts rather than workers who search out clients. One of these special public information efforts has been a campaign on child abuse to notify people in the community that it is a misdemeanor not to notify public officials about child abuse and to publicize, by brochure and radio, a "child abuse hotline." Another effort has been a program called "Generation Connection," which is designed to make the public more aware of older persons and their capabilities; however, this program does not convey information to older persons about the services they may be eligible for under Title XX program.[144]

A local-level administrator of the Title XX program in Washington State said that her agency's general outreach program consists of an information and referral system, distribution of printed material by caseworkers when they visit clients, informational notices in newspapers, a booth at a "volunteer fair," and pamphlets and posters in the waiting room of the office. She said that special outreach efforts are conducted regarding child protective services, where agency staff talk with police and school officials, and the early and periodic screening, diagnosis, and treatment program (EPSDT) under Medicaid, where community workers contact parents of children under 21 who have not followed up on referrals for additional care.[145]

In Missouri, a local official responsible for determining eligibility for the Title XX program, the aid to families with dependent children cash assistance program, food stamps, Medicaid, and the State program of cash assistance said that the Title XX program has no major advertising of benefits, and depends on other agencies to refer persons eligible for these programs to the agency.[146] The director of the local office said that the advertising of benefits that was done consisted of limited information and referral for income maintenance (AFDC) recipients, radio and television public service announcements, meetings with community groups regarding child abuse, and a 24-hour child abuse hotline.[147] The administrator of the purchase-of-service program at this same site said that there was no formal outreach program and not enough money for adequate outreach, despite her belief that there was a large population in the area, comprised of older persons and the "young adult" population, that had not heard about services available under the Title XX program.[148]

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[142] Eckert Interview.

[143] Berkshire Interview.

[144] John Moore, Title XX coordinator, Department of Public Welfare, interview in Austin, Tex., Apr. 27, 1977.

[145] Johnson Interview.

[146] Conley Interview.

[147] Nelson Interview.

As suggested by these descriptions of the types of outreach provided, transportation was not generally included as a service. Clients are expected to use whatever form of public or private transportation was available to get to a program delivery site unless there were special circumstances such as illness.[149]

Several administrators indicated that the reason their outreach efforts had been limited was that they were concerned about creating demand that could not be met.

A State administrator in Missouri said that the State does not have enough resources to serve every person eligible, and that the question becomes who you want to serve given limited resources.[150] A local administrator at this site agreed, saying that the persons responsible for Title XX are hesitant to over-promise on availability of services.[151]

A State administrator in Washington State said that the outreach program was not reaching all persons eligible for Title XX services, but questioned the desirability of improving it to reach all eligibles when the potential demand for services would exceed the supply. He also pointed out another problem that program administrators developing outreach programs face—the attitude of State legislators and the general public toward outreach.[152] He noted that the State is "conservative" with regard to providing any human service, and that State legislators and others do not always appreciate outreach efforts. As an example of this opposition, he related that one State legislator had called him personally to protest a mobile van advertising food stamps.[153]

A member of the staff of the agency responsible for the Title XX program in Illinois said that no advertising of services is done by the Illinois Department of Public Aid because of limited resources and a concern about creating demand that the Department cannot meet.[154]

Administrators at some sites commented that they did not believe that the outreach efforts that were being undertaken were particularly effective.

An administrator in Washington State said that outreach may be ineffective in reaching some persons because written information cannot be understood by people who are illiterate or have poor eyesight, and that the elderly, blind, and disabled particularly have difficulty understanding the written word. She concluded that because of these limitations, the best contact is face-to-face contact.[155]

Another Washington administrator said that he would like to change the outreach program to decrease newspaper and television coverage, which he considered ineffective, and increase efforts by community workers.[156] His views on needing more direct contact were supported by a Title XX administrator in Maine, who said that the outreach program could be improved by fostering better linkages between Department staff and staff in local government welfare programs, and by having staff "circuit-riders" for social services.[157]

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[148] Reser Interview.

[149] Martha Gulledge, acting director of social services, Department of Social Services, interview in Jackson, Miss., Apr. 27, 1977; Guber Interview.

[150] Hovis Interview.

[151] Washeck Interview.

[152] Quick Interview.

[153] Ibid.

[154] Eckert Interview.

[155] Johnson Interview.

The Commission was told that some efforts had been made to coordinate the social services program and the supplemental security income program, but that these efforts were only rarely considered successful. Orlando Romero, executive director of the Denver Department of Social Services, stated that Colorado did not have the kind of difficulties many areas had because he had worked with both the county welfare department and the supplemental security income program and "had learned the system at both ends."[158] Shirley Harris, social services administration supervisor for the Adams County, Colorado, Department of Social Services, said:

> . . .Colorado did not experience some of the difficulties [other areas of the country had] because there is a Colorado supplement. . .to the SSI payments, so people still have contact with the system. . . .Therefore, there is an appropriate avenue for outreach for informing clients of social services and related services.[159]

Reliance on Age Categorical Programs

Commission staff were told that the existence of age categorical programs to provide services and benefits to particular age groups is used to justify limiting the resources to support services to the age groups addressed by those categorical programs. In the areas visited in the field study and public hearings, Title XX program administrators said they depended on the programs authorized under the Older Americans Act to serve older persons and as a result made limited resources available for serving older persons.

Roger Doherty, executive director for the Denver Commission on Aging, testified:

> If we look carefully at what has happened in this State, and I am sure it is duplicated in other States, what we are finding is that agencies who are serving vulnerable groups of older people, in shuffling for scarce resources, are turning to Title III [of the Older Americans Act] and saying,. . ."Since these resources are available, you are going to have to fund services for the aging. . .out of these funds, and as a result we are not going to appropriate Title XX funds". . .
>
> I am concerned that Title XX funds may not be used quite to the extent that they should be to serve older

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[156] Quick Interview.

[157] Wilson Interview.

[158] Romero Testimony, *Denver Hearing*, pp. 118–119.

[159] Harris Testimony, *Denver Hearing*, p. 119.

> people because of the existence of these other funds. . . .[160]

This practice of taking into consideration the availability of Older Americans Act funds in allocating Title XX resources was also raised by Edwin Levine, of the Florida Department of Health and Rehabilitation Services. Mr. Levine, when asked how federally-assisted age categorical programs such as Title III and Title VII (of the Older Americans Act) are taken into account when allocating monies under Title XX, said:

> We attempt, to the best of our ability, to find out. . .what other resources, such as Title III and VII in this particular case, are used and where they are used, and we would like to use our Title XX funds to supplement and fill in the "gaps" between them. We attempt to coordinate, the best we can, with the other Federal sources of funds.[161]

George Tsismanakis, executive director of the Gulfstream Areawide Council on Aging in Riviera Beach, Florida, testified that the resources available to other age groups are not taken into consideration in the way that Older Americans Act resources are. He said that when advocacy groups questioned the State about the fact that only 4 percent of Title XX funds were available for services to older persons, they were told, "Just look at what Title III [of the Older Americans Act] is providing you." Mr. Tsismanakis went on to say:

> We hear of the $17 million that. . .[Title III and Title VII of the Older Americans Act] are providing, but we never hear about other monies available for other age groups. . .
>
> The State, in defending its horrendous allocations, has appealed to other resources available to the elderly but chooses not to look at other resources available to youth.[162]

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[160] Roger Doherty Testimony, *Denver Hearing*, p. 92.

[161] Levine Testimony, *Miami Hearing*, p. 199.

[162] Tsismanakis Testimony, *Miami Hearing*, pp. 198–199.

Chapter 2

Community Mental Health Centers

The community mental health centers program is authorized by the Community Mental Health Centers Act, as amended.[1] The act authorizes the provision of Federal financial assistance to public and nonprofit private agencies to meet part of the costs of providing comprehensive mental health services to individuals residing in defined geographic areas.[2]

The Commission's review of the program uncovered discriminatory practices on the basis of age in several areas. Both younger and older persons are adversely affected. Persons under 15 and persons 65 or over are seriously underrepresented among direct services recipients compared to their representation in the general population. Reliance on historical patterns of spending and service provision that favor adults operates to limit the participation of both younger and older persons in the program. Outreach activities (frequently referred to in the program as consultation and education activities) fail generally to address the older population. Parental consent requirements established under State law are reported to impede the ability of community mental health centers to serve younger persons. The lack of preservice and inservice training for treating children and older persons exacerbates the failure to serve these age groups adequately. Negative staff attitudes toward treating older persons contribute to their underrepresentation. Centers' staff take the supposedly higher costs of serving children and older persons compared to other age groups into consideration in deciding whom to serve. This has a negative impact on receipt of services by these age groups.

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[1] Community Mental Health Act, Pub. L. No. No. 88-164, 77 Stat. 290 (1963) [current version at 42 U.S.C. §2689 (Supp. V 1975)].

[2] 42 U.S.C. §§2689–2689p, 2689r–2689aa (Supp. V 1975).

Program Description

The purpose of the Community Mental Health Centers program is to promote and develop the delivery of community-based comprehensive mental health care by providing Federal financial assistance to public or private nonprofit agencies called community mental health centers.[3] The mission of the centers is to make possible the provision of an array of mental health services, principally to individuals residing in defined geographic areas, referred to as "catchment areas."[4] According to a National Institute of Mental Health summary, centers provide mental health services either "directly to persons in need or indirectly to persons at-risk through other community caretakers such as teachers, persons working in the health services delivery system, in public welfare agencies, in the criminal justice system, etc."[5]

The Community Mental Health Centers Act was enacted into law in 1963, as Title II of the Mental Retardation Facilities and Community Mental Health Centers Construction Act.[6] The legislation established a program that entitled States to receive Federal funds to assist in constructing community-based mental health treatment facilities called community mental health centers.[7] The intent of the program was to replace State and county mental health hospitals as the primary source of mental health care with a network of centers operating in every geographic area of the country.[8]

The act has been amended several times since 1963, and each succeeding law has added to the scope and requirements of the original program.[9] From the perspective of the Commission's study, the most noteworthy amendments occurred in 1970 and 1975. The Community Mental Health Centers Amendments of 1970 added, among other things, a special program to support construction of facilities to provide mental health services for children, to underwrite part of the related staffing and operations costs of centers, and to support special training and evaluation programs related to the mental health of children.[10] Inclusion of this new program appears to have been in response to evidence that the field of mental health, in general, and community mental health centers, in particular, were not effectively serving children.[11]

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[3] Community Mental Health Centers Amendments of 1975, Pub. L. No. 94-63, §301, 89 Stat. 308 (1975).

[4] 42 U.S.C. §§2689 (a)-(b) (Supp. V. 1975).

[5] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, *Community Mental Health Centers, the Federal Investment* (1977), p. 11 (hereafter cited as *Community Mental Health Centers*).

[6] Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, §200, 77 Stat. 290 (1963) [current version at 42 U.S.C. §2689 (Supp. V 1975)].

[7] *Id.*

[8] U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Health Revenue Sharing and Health Services Act of 1975*, 94th Cong., 1st sess., 1975, H.R. Rept. 192, pp. 34, 51-53 (hereafter cited as *Health Revenue Sharing Act*).

[9] For example, in 1965 the Community Mental Health Centers Act was amended to authorize, among other things, grants for the initial costs of staffing centers with professional and technical personnel. Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, Pub. L. No. 89-105, §220, 79 Stat. 428 (1965). The 1967 amendments to the act extended the authorizations for the construction and initial staffing grant programs and made possible acquisition of existing buildings for use as centers. Mental Health Amendments of 1967, Pub. L. No. 90-31, §§2-4, 81 Stat. 79. In 1968, the act was amended to authorize grants for the construction and staffing of programs to treat alcoholics and narcotic addicts. Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968, Pub. L. No. 90-574, §300, 82 Stat. 1006. The 1970 amendments effected a number of changes in the program. One feature was the authorization of construction and staffing assistance to centers to enable them to establish programs of mental services for children. Community Mental Health Centers Amendments of 1970, Pub. L. No. 91-211, §1, 84 Stat. 54. Amendments enacted in 1975 produced a general reorganization and revision of the program, including a requirement that centers include programs of specialized services for older persons and for children. Community Mental Health Centers Amendments of 1975, Pub. L. No. 94-63, Title III, §303, 81 Stat. 309 (1975) [codified at 42 U.S.C. §2681(Supp. V 1975)]. For a review of the legislative history of the act, see *Health Revenue Sharing Act*, pp. 34-40.

The most recent amendments to the Community Mental Health Centers Act occurred in 1975, when Congress passed the Health Revenue Sharing and Health Services Act of 1975[12] and heralded a major revamping of the community mental health centers program. The report of the House Committee on Interstate and Foreign Commerce, which accompanied the act, summarized the changes in the following manner:

> The new legislative authority. . .for the first time prescribe(s) a definition of CMHC and of the comprehensive mental health services which such a center must provide. The definition contains requirements for the organization and operation of such centers, provision of services, coordination of services with other entities and development of an integrated system of care, staffing, availability of services, responsiveness to the community served, governing bodies, quality assurance and related matters.[13]

Federal financial assistance is made available to public or nonprofit private agencies under five different grant authorities, each having its own eligibility and administrative requirements: (1) grants for planning community mental health center programs,[14] (2) grants for initial operation,[15] (3) grants for consultation and education services,[16] (4) conversion grants,[17] and (5) financial distress grants.[18] Federal financial assistance to States is also authorized under the facilities assistance grant program;[19] however, no funds have been appropriated to support such activities since fiscal year 1975.[20]

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[10] Community Mental Health Centers Amendments of 1970, Pub. L. No. 91–211, Title IV, §271, 84 Stat. 60 (repealed 1975).

[11] See, *Digest of Crisis in Child Mental Health: Challenge for the 1970s, Final Report of the Joint Commission on Mental Health of Children, Inc.* (Washington, D.C.: Joint Commission on Mental Health of Children, 1969) (hereafter cited as *Joint Commission Report*). The Joint Commission was established pursuant to the Social Security Amendments of 1965, Pub. L. No. 89–97 Part 4, §231, 89 Stat. 360 (1965).

[12] 42 U.S.C. §2689 (Supp. V 1975).

[13] *Health Revenue Sharing Act*, p. 53.

[14] 42 U.S.C. §2689a (Supp. V. 1975). Planning grants are available to public and nonprofit private entities for a 1-year period to develop plans for setting up community mental health centers. See also, *Health Revenue Sharing Act*, pp. 55–56 for a more detailed explanation of all of these grants.

[15] 42 U.S.C. §2689b (Supp. V 1975). Initial operations grants are available to public and nonprofit private community mental health centers and other public and nonprofit private entities that meet certain requirements of the act for the purpose of supporting the operational costs of a center. These grants are available on a declining Federal/non-Federal cost-sharing basis for a period not to exceed 8 years.

[16] 42 U.S.C. §2689c (Supp. V 1975). Consultation and education grants are available to community mental health centers to support the provision of the consultation and education services described at §2689(b)(1)(D) provided the centers meet other conditions specified in the act.

No grants may be made to any center or to other public or nonprofit private entities within a State unless the State has a plan for the provision of comprehensive mental health services approved by the Secretary of Health, Education, and Welfare.[21] The State mental health authority designated under Section 314(d) of the Public Health Service Act is responsible for the development and submission of the State plan.[22] To be approved, the State plan must, among other things, (1) set forth a program for community mental health centers within the State based on a statewide inventory of existing facilities and a survey of need for mental health services; (2) provide for the division of the State into sub-State geographic areas, called "catchment areas," based on the population distribution within the State; and (3) set forth the relative need of each catchment area's population for mental health services.[23]

In general, a community mental health center program operates through a primary service facility supported by a network of satellite centers located within the catchment area. Services are provided directly at the prime center and its satellites or through arrangements with other health service providers in the area.[24] Centers are hospital-affiliated or hospital-based or freestanding. They are generally staffed by psychiatrists, psychologists, social workers, registered nurses, and other mental health workers.

The 1975 amendments to the Community Mental Health Centers Act prescribed those services that a community mental health center must include in its program as a condition to obtaining or continuing to receive Federal funds.[25] Before these amendments, Federal regulations had required community mental health centers to provide five essential services: (1) inpatient services, (2) outpatient services, (3) partial hospitalization services including at least day care services, (4) emergency services provided 24 hours a day for at least one of the three services already identified, and (5) consultation and education services.[26] NIMH refers to the first four as "direct services" and to consultation and education activities as "indirect services."

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[17] 42 U.S.C. &2689d (Supp. V 1975). Conversion grants are available to enable existing centers to bring their programs into conformity with the new requirements of the 1975 amendments to the act.

[18] 42 U.S.C. &2689f (Supp. V 1975). Financial distress grants are made available to community mental health centers that meet certain eligibility requirements as specified in the act and can show that without such a grant, they would significantly reduce the types or quality of services provided or would be unable to provide the services mandated under §2689(b).

[19] 42 U.S.C. §2689i. Facilities assistance grants are designed to pay part of the costs for, among other things, acquisition, renovation, leasing, or construction of new facilities or expansion of existing facilities which will serve as community mental health centers.

[20] May Zarin, Doris Leake, National Institute of Mental Health, Department of Health, Education, and Welfare, telephone interview in Wash., D.C., Jan. 26, 1978.

[21] 42 U.S.C. §2689e(a)(Supp. V 1975).

[22] 42 U.S.C. §§2689r, t (Supp. V 1975); 42 U.S.C. 246(d)(1970). The State Mental Health Authority is also referred to as the "State Agency" or the "State Mental Health Agency."

[23] 42 U.S.C. §2689t (Supp. V 1975); 42 C.F.R. §§54.104 (b) and (c) (1976).

[24] 42 U.S.C. §2689(b)(2)(A)(Supp. V 1975).

[25] 42 U.S.C. §2689(b)(1)(Supp. V 1975). See also *Health Revenue Sharing Act*, p. 53.

The 1975 amendments, however, statutorily defined a program of comprehensive mental health services as consisting of 12 services, including the 5 originally prescribed by regulation. Existing and newly established centers were originally given 2 years to meet the new service requirements.[27] The act was amended in 1977 to extend the 2-year deadline to 3 years.[28]

Included among the newly mandated services are the following:

- a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and follow-up services (as prescribed by the Secretary of Health, Education, and Welfare.);

- a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

- inpatient services, outpatient services, day care and other partial hospitalization services, and emergency services;

- consultation and education services, which are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities, and include a wide range of activities (other than the provision of direct clinical services) designed to develop effective mental health programs in the center's catchment area, promote the coordination of the provision of mental health services among various entities serving the center's catchment area, [and] increase the awareness of the residents of the center's catchment area of the nature of mental health problems and the types of mental health services available; and

- provision of followup care for residents of the catchment area who have been discharged from a mental health facility.[29]

The report of the House Committee on Interstate and Foreign Commerce explained the reasons for having included the requirements for programs of specialized services for older persons and children:

> Community Mental Health Centers attempt to serve all in need within their catchment area responsibility. They have, however, lacked the resources, outreach programs, and incentives to deliver services to two groups with great needs, children and the aged. These "populations-at-risk"

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[26] 42 C.F.R. §54.212 (Supp. 1967).

[27] 42 U.S.C. §2689b (a)(1)(B)(iii)(Supp. V 1975).

[28] Health Services Extension Act of 1977, Pub. L. No. 95-83, Title III, §308, 91 Stat. 395 (1977).

[29] 42 U.S.C. §2689(b)(1)(A),(B),(C),(D), and (F)(Supp. V 1975).

> have special problems and only specially targeted programs and specially trained professionals are equipped to handle these patients and potential patients.
>
> A special categorical grant program was established in 1970 for children's programs. This has led to an expansion of services to this age group. . . .
>
> For persons at the opposite end of the spectrum, the aged, no comparable special grant program has existed. The number of elderly under care in community mental health centers and other outpatient psychiatric services as a proportion of all patient care episodes in these facilities in 1971 is quite small. . . .
>
> . . .[c]ommunity-based psychiatric facilities (community mental health centers, outpatient psychiatric services and transitional mental health facilities) are playing a relatively minor role in the care of the aged mentally ill. . . .[30]

The report adds later:

> In developing the CMHC legislation, Congress intended that all centers provide fully comprehensive programs for all residents in their catchment area. However, in practice many centers have been unable to develop the comprehensive and highly specialized programs needed by children and elderly persons and coordination between state mental hospitals and CMHC programs is often inadequate. While recognizing the resource constraints which have hampered provision of comprehensive specialized programs for children and the elderly, the Committee nonetheless believes that all CMHC's must offer these specialized services to be considered to have a comprehensive program.[31]

No Federal regulations have been published to implement the 1975 amendments.[32]

The community mental health centers program is administered by the National Institute of Mental Health (NIMH) within the Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Department of Health, Education, and Welfare (HEW). Administration of the program on a day-to-day basis is carried out under the Regional Health Administrator in each of the 10 HEW regional offices. These offices are responsible for the review and approval of State plans, the review and funding of applications, monitoring of community mental health centers through annual site visits, and provision of technical assistance to the centers. NIMH in Washington, D.C., is responsible for overall program and policy development and implementation.[33] According to NIMH, from fiscal year 1966 through fiscal year 1976, Federal funds have helped start 650 centers.[34]

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[30] *Health Revenue Sharing Act*, pp. 45–6.

[31] Ibid., p. 54.

[32] Interim regulations governing State plans and certain other administrative requirements pursuant to the act were published on June 30, 1976. 42 C.F.R. Part 54 (1976); proposed regulations covering the requirements and standards governing the mandatory services and grant authorities pursuant to the act were published on Nov. 2, 1976. 41 Fed. Reg. 48, 242 (1976).

[33] Ford Kuramoto, D.S.W., Executive Assistant to the Director, Division of Mental Health Service

Summary of the Record

Program Participants

Data show that persons under 15 and those 65 or over are not being served by community mental health centers, either in relation to their numbers in the catchment area population or in relation to their need for mental health care.

Each year, in cooperation with the State mental health authorities, the National Institute of Mental Health (NIMH) conducts a survey of federally-funded community mental health centers.[35] During 1975, the survey showed that 528 centers added 919,000 new patients to their direct services patient caseloads.[36] NIMH refers generally to new patients as "additions," defined as the unduplicated count of persons admitted to the CMHC system of care during a reporting year.[37] "Caseload" includes all persons under care, meaning the unduplicated count of patients served, which is calculated by adding the additions during the reporting year to the residual caseload from the previous reporting year.[38] "Direct services" includes all services except for consultation and education, which are classified as "indirect services."[39]

According to NIMH staff, 328 of the 528 centers operating in 1975 met the agency's reporting standards for numbers of new patients.[40] Table 2.1 compares the age distribution of the catchment area population, U.S. population estimates, and new patients for the 328 centers.

It is interesting to note that the U.S. population estimates closely approximate the catchment area population figures. Although persons between 15 and 44 made up 41.2 percent of the catchment area population, they represented 64.5 percent of the new patient caseload. In contrast, persons in the age groups under 15, 45 to 64, and 65 or over were underrepresented compared to their presence in the catchment area population. Chart 2.1 graphically depicts the data presented in table 2.1.

Programs, National Institute of Mental Health, interview in Wash., D.C., Jan. 7, 1977.

[34] *Community Mental Health Centers*, p. 10.

[35] Ibid., note 1, p. 35. The instrument used in the survey is called the "Inventory of Comprehensive Mental Health Centers."

[36] Ibid., pp. 20, 23.

[37] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, *Provisional Data on Federally Funded Community Mental Health Centers, 1975–76* (1977), p. 42 (hereafter cited as *Provisional Data, 1975–76*). The definition includes those individuals who received care and were discharged in a prior year but were readmitted during the reporting year.

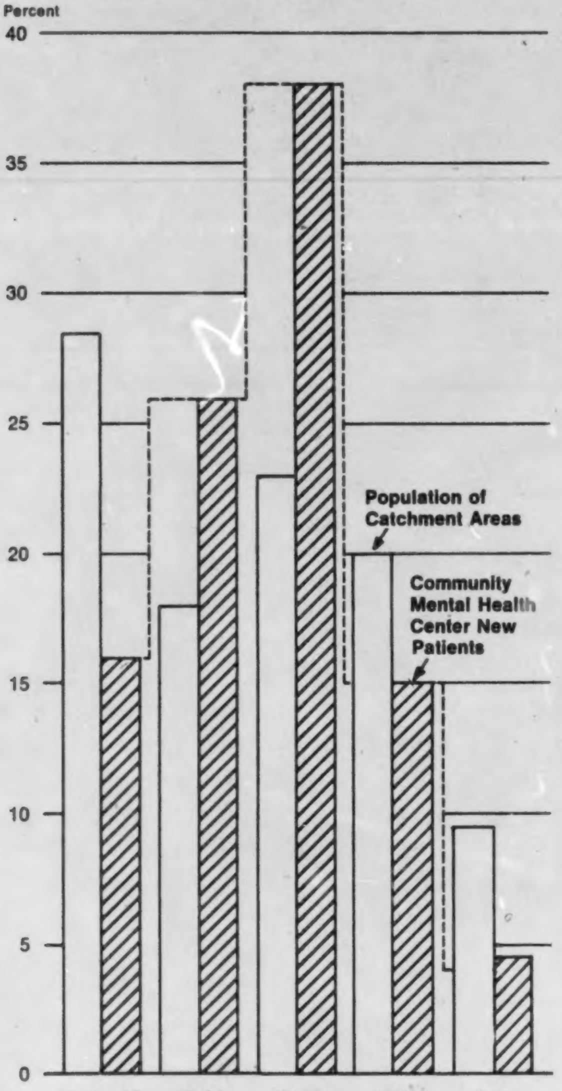
[38] *Community Mental Health Centers*, notes 4-5, pp. 35-6.

[39] Ibid., p. 31.

[40] Rosalyn Bass, Survey and Reports Branch, National Institute of Mental Health, telephone interview in Wash., D.C., Nov. 29, 1977. Ms. Bass added that several factors contributed to determining the final number of centers (328) which met reporting standards. These factors included (1) centers lacking data or unable to classify additions by race/sex/age were excluded; (2) at least 80 percent of a center's additions had to be catchment area residents and this excluded centers that are part of county operations (she estimated that 10 to 15 percent of the centers fell into this category); and (3) demographic information for the catchment area had to be available, which eliminated centers in Guam and Puerto Rico that do not serve traditionally defined catchment areas.

Chart 2.1

Distribution of new community mental health center patients by age, 1975



Comparison of catchment area population with new community mental health center patients by age, based on 328 centers.

Source: U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Mental Health Service Programs, and Division of Biometry and Epidemiology, unpublished data.

Table 2.1
Percent Distribution of U.S. Population, Catchment Area Population, and New Community Mental Health Center Patients by Age, 1975

Age Groups	U.S. Population Estimates[a]	Catchment Area Population[b]	New Patients[b]
All Ages	100.0%	100.0%	100.0%
Under 15	25.1	28.8	16.3
15-24	18.5	18.1	26.1
25-44	25.0	23.1	38.4
45-64	20.6	20.1	15.1
65 +	10.6	9.9	4.1

Source: [a] U.S., Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P-25, no. 643. table 3;
[b] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, unpublished data. Data are for 328 centers.

Table 2.2
Percent Distribution of New Community Mental Health Center Patients by Age, 1975

Age Groups	New Patients	
All Ages	100.0%	
Under 15	16.0	
15-17	7.3	26.1
18-24	18.8	
25-44	38.5	
45-64	15.4	
65 +	4.0	

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, *Community Mental Health Centers, The Federal Investment* (1977), p. 23. Data are for 528 centers.

sentation in the population, U.S. population figures reported by the Bureau of the Census were used. Whether catchment areas served by the operating centers were representative of the U.S. population at any time is unknown; however, it is

NIMH made estimates for the 200 operating centers that failed to meet the reporting standards.[41] The resulting data for the universe of 528 centers show substantially the same distribution patterns for new patients as were evidenced for the 328 reporting centers. (See table 2.2.) Those between 25 and 44 constituted the largest percentage of new patients. Those under 18 made up nearly one-fourth, while those 65 or over were 4 percent of the new patients.

The 1975 age distributions of new patients do not vary substantially from those reported in previous years. In fact, the participation levels of children and older persons in the CMHC program have represented a continuing pattern of underservice for some time.[42] Following is a presentation of new patient data for each year from 1968 through 1975. For some years, catchment area population data were not available; therefore, to make some comparisons between the age distributions of new patients and their repre-

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[41] Ibid. For the 200 centers for which insufficient data were available (528 minus 328), NIMH made estimates of new patients based on, among other things, the number of years they had been in operation. This is how NIMH arrived at the figure of 919,000 new patients for the universe of 528 operating centers.

[42] On older persons' participation, see, for example, U.S., Congress, Senate, Special Committee on Aging, *Mental Health Care and the Elderly : Shortcomings in Public Policy*, 92d Cong., lst sess., 1971, Comm. print, pp. 21–22 (hereafter cited as *Mental Health and the Elderly*); Robert D. Butler, *Why Survive? Being Old in America* (New York: Harper and Row, 1975), pp. 236–40 (hereafter cited as *Why Survive?*); and tables presented in the text. On children's participation see, for example, *Mental Health Services for Children*, pp. 14–15. On both age groups' participation, see *Health Revenue Sharing Act*, pp. 45–46 and 54.

Table 2.3
Percent Distribution of U.S. Population and New Community Mental Health Center Patients by Age and Type of Service Provided, 1968

Age Groups	U.S. Population Estimates[a]	New Patients[b]		
		24-Hour Care*	Partial Care**	Outpatient Care***
All Ages	100.0%	100.0%	100.0%	100.0%
Under 15	**29.8**	**3.5**	**6.1**	**17.9**
Under 5	9.1	.1	.7	1.4
5-9	10.4	.7	3.3	7.4
10-14	10.3	2.7	2.1	9.1
15-24	**16.2**	**19.8**	**25.4**	**25.0**
15-17	5.7	4.5	4.2	7.1
18-19	3.4	4.4	5.1	4.9
20-24	7.1	10.9	16.1	13.0
25-44	**23.6**	**40.6**	**42.1**	**38.0**
25-34	11.8	20.3	23.6	21.2
35-44	11.8	20.3	18.5	16.8
45-64	**20.7**	**28.6**	**22.5**	**15.9**
45-54	11.5	17.3	14.9	10.1
55-64	9.2	11.3	7.5	5.8
65+	**9.8**	**7.6**	**4.0**	**3.3**
65-74	6.2	5.0	2.9	2.4
75+	3.6	2.6	1.1	.9

** Based on reports from 54 centers. *** Based on reports from 47 centers. ** Based on reportes from 45 centers.

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P-25, no. 519, table 3.

[b] U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, National Clearinghouse for Mental Health Information, *Statistical Note 13* (1970), pp. 3, 9, 15.

interesting to note that for those years for which both catchment area and U.S. population figures are available, the age distributions are very similar. In addition, variations exist in the age categories used in reporting new patients for some years. To make some comparisons over years, data and age groups have been collapsed where possible. Any variations exist primarily at the younger age categories.

According to NIMH, 165 community mental health centers were in operation for at least one month in 1968. The number of centers reporting data on, among other things, the age-diagnostic distribution of additions to centers was considerably less than 165; however, NIMH indicated that, based on its analysis, the reporting centers could be considered representative of all 165 operating centers.[43] Table 2.3 presents the provisional age participation data by the three service categories reported: 24-hour care, partial care, and outpatient care.

Assuming that the U.S. population estimates approximated the catchment area population, the data indicate that persons under 15 and persons 65 or over are generally underrepresented in the CMHC caseload. Total patient additions were not reported for 1968; however, patterns of age participation by service category are noteworthy in that certain age groups are far less represented than others within each category. NIMH reported:

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[43] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, National Clearinghouse for Mental Health Information, Office of Program Planning and Evaluation, Biometry Branch, Survey and Reports Section, *Statistical Note 13* (1970), p. 1.

> It is. . .seen that additions to 24-hour and partial care services were largely concentrated in the young adult and middle age groups (20–54) with fewer elderly (65 years and over) and children and adolescents (under 18 years) being admitted to these services. For outpatient care services the pattern was generally much the same except that proportionately higher numbers of persons under 18 years were admitted.[44]

In 1969, 205 centers were in operation. Assuming that no significant differences existed between the reporting centers and the ones in operation, NIMH estimated totals for the universe of operational centers.[45] Table 2.4 presents the age distribution of the new patients and the U.S. population estimates. Those under 18 and those over 54 are less well represented in the patient population than in the general population.

In 1970, 255 centers were in operation and admitted an estimated 335,000 new patients.[46] Table 2.5 compares the U.S. population figures to the new patients admitted to all centers but those in Puerto Rico. Slight declines or increases occurred for all age groups except for those 65 or over; their participation level remained at the same level as in 1969—3.9 percent. Those under 20 continued to be underrepresented compared to their representation in the general population; however, the sub-group aged 15 to 19 was overrepresented. The data thus indicate that the underrepresentation suggested by the aggregated age group "under 20" in 1969 (see table 2.4) may actually occur at a younger age at least—under 15. Compared to the U.S. population, the age groups 45 to 64 and 65 or over were also underrepresented. However, the 1969 figures for the more discrete age groups 45 to 54 and 55 to 64 indicate that what appears to be an aggregate underrepresentation of those 45 to 64 in 1970 may actually be a function of underrepresentation of the 55 to 64 age group, as shown by the 1969 figures.

One observation worth making at this point is the need to have sufficiently discrete age classifications to enable a more precise identification of where problems may actually be occurring. The age categories reported by NIMH were aggregated after 1969 and again after 1972, thus impeding to some extent the analyses that could be made if more discrete categories had been used.

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[44] Ibid.

[45] U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 59* (1971), p. 1.

[46] U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 67* (1972), pp. 1-2.

Table 2.4

Percent Distribution of U.S. Population and New Community Mental Health Center Patients by Age, 1969

Age Groups	U.S. Population Estimates[a]	New Patients[b]
All Ages	100.0%	100.0%
Under 18	35.0	21.1
18-19	3.4	5.6
20-24	7.3	13.7
25-34	12.0	20.7
35-44	11.5	16.7
45-54	11.5	11.6
55-64	9.2	6.7
65-74	6.2	2.7
75+	3.7	1.2

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P-25, no. 519, table 8.

[b] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 59* (1971), table A. Data are for 205 centers.

Table 2.5

Percent Distribution of U.S. Population and New Community Mental Health Center Patients (Excluding Puerto Rico) by Age, 1970

Age Groups	U.S. Population Estimates[a]		New Patients[b]	
All Ages	100.0%		100.0%	
0-4	8.5	28.7	1.1	15.5
5-14	20.2		14.4	
15-19	9.4	17.7	12.6	27.2
20-24	7.7		14.6	
25-44	23.5		36.2	
45-64	20.8		17.2	
65+	10.0		3.9	

* Based on 318,974 new patients.

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P-25, no. 614, table 3.

[b] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 67* (1972) p. 5.

Table 2.6

Percent Distribution of U.S. Population, Catchment Area Population, and New Community Mental Health Center Patients by Age, 1971

Age Groups	U.S. Population Estimates[a]	Catchment Area Population[b]	New Patients[b]
All Ages	100.0%	100.0%	100.0%
0-4	8.4	8.5	1.0
5-14	19.8	20.1	12.4
15-19	9.5	9.9	12.7
20-24	8.2	8.7	14.4
25-44	23.4	23.4	36.6
45-64	20.7	19.6	18.9
65+	10.0	9.9	4.0

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P-25, no. 614, table 3.

[b] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 86* (1973), pp. 18–19. Data are for 69 centers.

In 1971 there were an estimated 432,640 new patients added to the caseloads of 295 centers.[47] NIMH conducted a special anaysis of a sample of 69 centers which showed that older persons accounted for nearly 10 percent of the catchment area population but only 4 percent of the centers' new patient population.[48] Table 2.6 compares the new patients for the 69 centers with the U.S. population estimates and the catchment area population.[49] The general and catchment area population bases closely approximate each other. Those in the age groups of birth to 4, 5 to 14, 45 to 64, and 65 or over were underrepresented to varying degrees, while the groups aged 20 to 44 accounted for nearly two-thirds of all new patients. All age groups experienced some slight increase or decrease over 1970. Older persons' (65+) participation rose over 1969 and 1970, but by a mere .1 percent. Those 45 to 64 increased to 18.9 percent, or 1.7 percent over 1970 and .6 percent over 1969. The 25-to-44-year-old group had a slight increase of .4 percent over 1970, while participation of the group 20 to 24 declined slightly from 1970 but was higher than for 1969. Participation of those 15 to 19 increased by the same margin as those 65 or over while, those 5 to 14 saw a decline of 2 percent. A comparison between the figures reported for the 69 centers and those for all centers operating in 1971 shows generally the same patterns of participation by age. (See table 2.7.) Persons 45 or over, however, were reported at a lower participation level for all centers than for the 69. (1972 CMHC data were not available to the Commission.)

In 1973, 261 of 391 operating centers (excluding Guam and Puerto Rico) reported the addition of 419,107 patients to their caseloads.[50] (See table 2.8.) Compared to the 1971 figures for 69 centers (see table 2.6), the age group under 15 increased by 3.3 percent, the group 45 to 64 declined by 3.1 percent, and the group 65 or over declined by .2 percent. The decrease for the group aged 65 or over is slight, but when considered with the constancy of its participation level and the disparity between its representation in the general or the catchment area populations, the figure takes on somewhat greater significance.

In 1976 NIMH published provisional data on 434 centers in operation in 1974.[51]

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[47] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, *Statistical Note 87* (1973), p. 1.

[48] U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 86* (1973), p. 19 (hereafter cited as *Statistical Note 86*). According to NIMH, the 69 centers were selected based on the availability of demographic information for the catchment areas in which the centers were located, and criteria for completeness of reporting on the inventory forms. p. 17.

[49] Catchment area population figures were derived from the 1970 U.S. Census of Population. Ibid., p. 17.

[50] U.S., Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, *Statistical Note 126* (1976), p. 9.

[51] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, *Provisional Data on Federally Funded Community Mental Health Centers*, 1974-75 (1976), p. i. Of the 434 operating centers, 410 completed the inventory form. NIMH estimated for the missing centers or for the missing data

Table 2.7
Comparison of Percent Distribution of U.S. Population, Catchment Area Population, and New Patients for 295 and for 69 Community Mental Health Centers by Age, 1971

Age Groups	U.S. Population Estimates[a]	New Patients 295 Centers[b]	Catchment Area Population[c]	New Patients 69 Centers[c]
All Ages	100.0%	100.0%	100.0%	100.0%
0-4	8.4	1.0	8.5	1.0
5-14	19.8	13.3	20.1	12.4
15-19	9.5	13.1	9.9	12.7
20-24	8.2	15.5	8.7	14.4
25-44	23.4	36.9	23.4	36.6
45-64	20.7	16.6	19.6	18.9
65+	10.0	3.5	9.9	4.0

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P-25, no. 614, table 3.

[b] U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, *Statistical Note 87* (1973), p. 7.

[c] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 86* (1973), pp. 18–19.

Table 2.8
Percent Distribution of U.S. Population, Catchment Area Population, and New Community Mental Health Center Patients by Age, 1973

Age Groups	U.S. Population Estimates[a]	Catchment Area Population[b]	New Patients[b]
All Ages	100.0%	100.0%	100.0%
Under 15	26.8	28.8	16.7
15-24	18.1	18.1	27.0
25-44	24.3	23.3	36.8
45-64	20.7	20.1	15.8
65+	10.3	9.8	3.8

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P–25, no. 614, table 3.

[b] U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, *Statistical Note No. 126* (1976), p. 10. Data are for 261 centers.

Table 2.9
Percent Distribution of U.S. Population and New Community Mental Health Center Patients by Age, 1974

Age Groups	U.S. Population Estimates[a]	New Patients[b]
All Ages	100.0%	100.0%
Under 15	26.0	16.7
15-24	18.3	26.3
25-44	24.6	37.1
45-64	20.6	16.0
65+	10.4	3.9

Source: [a] U.S. Department of Commerce, Bureau of the Census, *Current Population Reports*, Series P–25, No. 643, Table 3.

[b] U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, *Provisional Data on Federally Funded Community Mental Health Centers, 1974–75* (1976), p. 20. Data are for 434 centers.

Table 2.10
Percent Distribution of New Community Mental Health Center Patients by Age, 1969-1975

Age Groups	New Patients						
	1969	1970	1971	1972	1973	1974	1975
All Ages	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under 15	13.0	15.4	14.3	17.2	16.7	16.7	16.0
15-24	26.5	27.3	28.6	26.9	26.7	26.3	26.1
25-44	37.6	36.2	36.9	35.9	36.8	37.1	38.5
45-64	18.9	17.2	16.6	16.2	16.0	16.0	15.4
65 +	4.0	3.9	3.5	3.8	3.8	3.9	4.0

Source: U.S. Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, *Provisional Data on Federally Funded Community Mental Health Centers 1975–76* (1977), p. 35.

The data show substantially the same levels of participation as for 1973. (See table 2.9 for the 1974 data.) More recently, NIMH has published a compilation of final (as opposed to provisional) new patient data for the years 1969 to 1974 and provisional data for 1975.[52] Table 2.10 provides a summary view of the age distribution patterns for 1969 to 1975. No significant differences appear from the data that had been reported on an annual basis.

Persons under 15 have experienced an increase of 3 percent since 1969. Their representation reached a peak in 1972 and has declined since. Participation levels of those 15 to 24 and 25 to 44 have remained relatively stable with some slight fluctuations from year-to-year. Participation of those 45 to 64 has steadily declined since 1969 with an overall decline of 3.5 percent. (Because in general the variations from year-to-year for all ages were slight, the situation of the 45 to 64 age group is noteworthy). Representation of those 65 or over has hovered at or below 4 percent for the entire period.

An examination of the age-specific addition rates for 69 centers in 1971, 261 centers in 1973, and 328 centers in 1975 also shows the extent to which certain age groups are underrepresented or overre-

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for reporting centers that failed to meet standards.

[52] U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch, *Provisional Data on Federally Funded Community Mental Health Centers, 1975-76*, p. 35. The 1975 data are provisional. They are the same data reported for 528 centers in *Community Mental Health Centers*, p. 23, cited above.

Table 2.11
Community Mental Health Center Patient Addition Rates Per 100,000 Catchment Area Population by Age, 1971, 1973, and 1975

	Addition Rates		
Age Groups	**1971**[a]	**1973**[b]	**1975**[c]
All Ages	896.7	1,069.9	1,144.8
Under 15	420.2	621.5	647.5
15-24	1,305.0	1,596.0	1,653.4
25-44	1,406.1	1,691.1	1,904.9
45-64	866.1	838.2	859.3
65+	361.7	412.7	474.1

Source: [a] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 86* (1973), p. 18. Data are for 69 centers.

[b] U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, *Statistical Note 126* (1976), p. 15. Data are for 261 centers.

[c] U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, *Community Mental Health Centers, The Federal Investment* (1977), p. 20. Data are for 328 centers.

presented in the community mental health centers programs. Addition rates involve a comparison of the number of new patients within an age group to the number of persons within that group in the catchment area population. If age were not a factor in the program, addition rates for each group should approximate the rate for all age groups. Table 2.11 presents the age-specific addition rates for 1971, 1973, and 1975.

In each year, significant disparities exist between the rate for all age groups and that for those 65 or over; the aggregate rate is about 2.5 times that for older persons. The next greatest disparity occurs for those under 15. Although a relatively large increase in participation occurred between 1971 and 1973, the group remained underrepresented by a substantial margin. Although data are presented in the aggregate for the age group under 15, NIMH reported that in 1971 the addition rate was 107.5 for the population under 5 and 552.1 for those 5 to 14.[53] NIMH summarized the 1975 addition rate data as follows: "Relative to their numbers in the [catchment] area, children are served at roughly one-third the rate and the elderly at less than one-fourth the rate of the 25-44-year-old group."[54] This statement accurately describes the situation in 1973 as well. In 1971 the comparisons to the 25 to 44 age group were even less favorable for those under 15.

The rate each year for those 45 to 64 is also well shy of the rate for all ages. In

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[53] *Statistical Note 86*, p. 8.

[54] *Community Mental Health Centers*, p. 20.

Table 2.12
Changes in Community Mental Health Center Addition Rates Per 100,000 Catchment Area Population by Age, 1971-1975

	Base Addition Rate	Addition Rate Changes		
Age Groups	**1971**	**Change 1973 over 1971**	**Change 1975 over 1973**	**Change 1975 over 1971**
All Ages	896.7	+173.2	+74.9	+248.1
Under 15	420.2	+201.3	+26.0	+227.3
15-24	1,305.0	+291.0	+57.4	+348.4
25-44	1,406.1	+285.0	+213.8	+498.8
45-64	866.1	−27.9	+21.1	−6.8
65+	361.7	+51.0	+61.4	+112.4

Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, *Statistical Note 86* (1973), p. 18.

U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, *Statistical Note 126* (1976), p. 15.

U.S. Department of Health, Education, and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute of Mental Health, *Community Mental Health Centers, The Federal Investment* (1977), p. 20.

Table 2.13
Percent Distribution of Catchment Area Population and Patients Served by 9 Community Mental Health Centers

Centers	Percent in Catchment Area					Percent Served by Center				
	Under 5	**5-19**	**20-44**	**45-64**	**65+**	**Under 5**	**5-19**	**20-44**	**45-64**	**65+**
Center #1	8.1	28.7	29.2	21.1	12.9	1.2	23.8	55.8	17.4	1.8
Center #2	9.2	32.4	36.7	15.5	6.2	5.3	54.7	32.7	7.3	—
Center #3[a]	10.6	32.8	30.7	18.3	7.6	1.4	20.1	54.8	16.7	4.2
Center #4	6.9	22.1	29.2	25.9	15.9	2.3	19.5	47.4	27.8	3.0
Center #5	8.4	24.1	32.5	20.6	14.4	.4	15.8	62.2	18.0	3.6
Center #6	10.0	35.7	36.4	14.3	3.6	—	22.7	63.2	12.9	1.2
Center #7	6.9	24.5	34.9	21.0	12.7	—	11.8	61.8	26.4	—
Center #8	9.0	33.6	27.7	20.5	9.2	3.1	47.2	38.7	9.8	1.2
Center #9	7.2	31.1	25.4	22.8	13.5	1.1	19.5	55.3	20.7	3.5

[a] Information not available on 28 percent of records sampled.

Source: U.S., General Accounting Office, *Need for More Effective Management of Community Mental Health Centers Program* (1974), Appendix III.

contrast, the rates for those 15 to 24 and 25 to 44 well exceed the rate for all ages.

Table 2.12 presents the addition rate changes for all three years using 1971 as the base addition rate year. The data reveal, even further, disparities within the program. If age were not a factor, the rate change for each age group should approximate that for all age groups.

In 1973 fairly substantial changes over 1971 occurred for most age groups. The rate change for those under 15 exceeded the rate for all groups. This may be attributable in part to implementation of the 1970 amendments to the Community Mental Health Centers Act which made special program provisions for children.[55] The rate changes for those 15 to 24 and 25 to 44 also exceeded the aggregate rate but far more substantially. The addition rate for those 45 to 64 declined in 1973 over 1971. This is the only group showing a decline. Those 65 or over experienced an increase, but significantly below the rate change for all ages.

The rate changes for 1975 over 1973 are less significant in general than those for 1973 over 1971. This may be attributable in part to the increases in program appropriations for 1972 and 1973.[56] Although the rate changes increased for all age groups, the change for those 25 to 44 was the only one that exceeded the aggregate rate change. Those under 15 and those 45 to 64 had the lowest rate changes—one-eighth of the change for the 25-to-44-year-old group. The rate change for those 25 to 44 is nearly four times that of the 15 to 24 and more than three times that of the 65 or over age groups.

Examination of the rate changes over the entire period shows a net decrease for those 45 to 64. Persons 45 to 64 and 65 or over have substantially lower rate changes than any other age group. The rate change for those 25 to 44 is nearly five times that for those 65 or over and twice that for all ages. Although the net change for those under 15 nears that for all ages, the significant change occurred between 1971 and 1973. In sum, those 15 to 24 and those 25 to 44 have been added to the program at a significantly greater rate than any other age group. Those 45 or over have been added at a significantly lower rate than any other age group.

In addition to NIMH's national data on program participants, others have also cited underservice to children and older persons as a problem within the community mental health centers program. In 1974, in conjunction with congressional consideration of the 1975 amendments to the Community Mental Health Centers Act, the General Accounting Office (GAO) issued a report to the Congress of its study

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[55] The 1970 Amendments to the Community Mental Health Centers Act authorized construction and staffing assistance to centers to enable them to establish specialized programs of mental health services for children. Community Mental Health Centers Amendments of 1970, Pub. L. No. 91-211, §1, 84 Stat. 54.

[56] The total appropriations for the community mental health centers program were $90,100,000 in 1971. This increased to $160,100,000 in 1972 and to $205,100,000 in 1973. In 1974, $198,698,000 was appropriated, less than the amount for 1973. In 1975, $213,151,000 was appropriated restoring the program to more than its 1974 level. These data were obtained from U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Office of Program Support.

Table 2.14

Percent Distribution of Catchment Area Population and New Patients for 10 Community Mental Health Centers by Age, 1975

Centers	Catchment Area Population[a]						New Patients[a]					
	Total	Under 15	15-24	25-44	45-64	65 +	Total	Under 15	15-24	25-44	45-64	65 +
Bexar County MR/MH Center, Southeast ,Tex.	100.0%	32.0%	17.6%	22.8%	19.1%	8.5%	100.0%	30.7%	19.7%	24.1%	12.7%	12.8%
Bexar County MR/MH Center, Southwest, Tex.	100.0	36.1	25.6	22.8	11.7	3.8	100.0	21.5	21.8	32.6	16.3	7.7
Edgewater Uptown CMHC, Chicago, Ill.	100.0	18.5	15.6	26.6	22.7	16.6	100.0	9.4	24.2	37.1	21.2	8.1
Kennebec Valley MH Center, Maine	100.0	29.1	15.9	22.2	21.2	11.6	100.0	20.8	24.0	36.9	13.8	4.5
Highline-West Seattle CMHC, Wash.	100.0	28.7	17.3	24.7	21.2	8.0	100.0	7.8	31.1	48.2	10.9	1.9
Tri-County CMHC, Mo.	100.0	30.5	16.3	27.4	18.7	7.1	100.0	11.9	27.6	36.0	19.9	5.5
Park East Comprehensive CMHC, Colo.	100.0	24.6	19.8	25.5	19.1	11.0	100.0	7.5	31.3	47.6	12.9	0.6
Westside CMHC, SFO	100.0	15.6	18.9	30.7	21.2	13.5	100.0	7.0	26.0	53.8	10.3	2.9
Southeast CMHC, SFO	100.0	26.5	17.9	22.3	23.2	10.1	100.0	15.2	22.2	38.9	11.8	12.0
Jackson Memorial Hospital Center, Miami, Fla.	100.0	27.2	15.1	24.9	20.6	12.2	100.0	7.4	19.6	40.9	20.3	11.8

[a] Percents may not sum to 100.0 because of rounding.

Source: U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry, and Epidemiology, Survey and Reports Branch, unpublished data.

of the management activities of 12 community mental health centers.[57] Based on an analysis of patient records at 11 centers and population data for their catchment areas, the GAO concluded:

> Children under age 5 and persons age 65 and over were underserved in proportion to their numbers in the catchment areas. Persons age 20 to 44. . .are represented on patient records in numbers well above their proportion in the catchment area.[58]

Table 2.13 presents the data reported by GAO for 9 centers. (Data appear to have been unavailable or exceptionally limited for the other 26 centers.) In every instance, children under 5 and persons aged 65 or over were seriously underrepresented. Except for one center, those between 20 and 44 were overrepresented. In all but two centers, those between 5 and 19 were underrepresented to varying degrees. The same was true for those between 45 and 64.

A 1971 study of community mental health centers conducted by the Joint Information Services of the American Psychiatric Association also showed underrepresentation of children in community mental health centers. Based on responses from 143 centers on questions about services provided to children and adolescents and their representation in the centers' patient caseloads, the authors concluded that, except for consultation and education services, children and adolescents were considerably underserved in all service categories compared to their proportion in the population, although adolescents fared better than children.[59]

In another study, older persons were found to be underrepresented. Dr. Robert Dovenmuehle reported to the U.S. Senate Special Committee on Aging in 1971 on his survey of 134 centers: "It is clear that in most of the comprehensive community mental health centers, problems of the aged are not being adequately reached."[60]

Participant data and other documentary information available for some of the community mental health centers covered in the Commission's field study and public hearings showed problems of service delivery to children and older persons. NIMH included 10 of the 13 community mental health centers that Commission staff visited in its 1975 group of 328 centers that met agency reporting standards for new patients.[61] Table 2.14

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[57] U.S., General Accounting Office, *Need for More Effective Management of Community Mental Health Centers Program* (1974), p. i (hereafter cited as *GAO Report*). See appendix II, p. 84 of the report, for a listing of the centers covered. This was a followup to an earlier study conducted by GAO and reported on July 8, 1971.

[58] Ibid., p. 11.

[59] Raymond M. Glasscote and others, *Children and Mental Health Centers: Program Problems and Prospects* (Washington, D.C.: Joint Information Services of the American Psychiatric Association and the National Association for Mental Health, 1972), p. 45. The authors also indicate variations in the upper age limits used to define "children" and "adolescents." see p. 41.

[60] Robert H. Dovenmuehle, "A Review of the Impact of the Community Mental Health Center Movement on Psychiatric Services to Senior Citizens," in *Mental Health Care and the Elderly,* appendix 2, item 4, p. 179.

[61] Three centers that were visited by Commission staff were not included among the 328 centers which met NIMH reporting standards. The Jackson Mental Health Center in Jackson, Mississippi, was excluded because only 79 percent of its new

presents the catchment area populations and new patients reported by the 10 centers for 1975.

All 10 centers show the age group under 15 as being underrepresented compared to its presence in the catchment area population. The proportion of new patients under 15 was less than one-third the proportion that age group represented in the catchment area population of three centers: Highline-West, Park East, and Jackson Memorial. Three more centers had patient proportions that were approximately one-half the representation of the under 15 age group in their catchment area populations: Edgewater, Tri-County, and Westside.

In all but one center the age group 15 to 24 is overrepresented to varying degrees. The age group 25 to 44 is overrepresented significantly in all but one center. In the Highline-West Seattle center, the group's proportion of new patients is just under two times its representation in the catchment area population.

Persons aged 45 or over are underrepresented in eight centers; however, in two of these underrepresentation is slight—by .3 percent in one and by 1.5 percent in another. The greatest disparities occurred in the Southeast, Westside, and Highline-West Seattle community mental health centers. This age group was overrepresented by 4.6 percent in one center and 1.2 percent in another.

Persons 65 or over are underrepresented in seven centers. In two of these centers, underrepresentation is slight—.4 percent, and 1.6 percent, respectively. The most striking disparities occurred in the Edgewater-Uptown, Park East Comprehensive, and Westside community mental health centers. Only 4 of 636 patients for the Park East center were 65 or over. The age group was overrepresented in three other centers.

Catchment area population and new patient data for the 10 centers for 1975 were aggregated and recalculated to determine what differences, if any, existed between data for 10 of the centers included in the Commission's study and the national data reported that year for the 328 centers.(See table 2.1.) The results are as follows:

- **Under 15**— While the exact proportions differ, the data for both the 328 and the 10 centers reveal substantial differences between the carchment area populations and new patients. Persons in this group represented 28.8 percent of the catchment area population for the 328 centers and 16.3 percent of the additions. For the 10 centers visited by the Commission, those under 15 represented 27.3 percent of the catchment area population and 13 percent of the new patients.

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patients were catchment area residents. NIMH standards require that 80 percent be catchment area residents. Ravenswood Hospital Medical Center in Chicago, Illinois, was excluded because the center uses age categories different from NIMH's and only 60 percent of its patients were catchment area residents. Finally, the Northwest Denver Community Mental Health Center was excluded because only 70 percent of its new patients were catchment area residents. U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry and Epidemiology, Survey and Reports Branch.

- **15 to 24**— For the 328 centers, this group represented 18.1 percent of the catchment area population and 26.1 percent of new patients, with a disparity of positive 8 percent. For the 10 centers, the group represented the same proportion of the population but 24.3 percent of additions, producing a disparity of positive 6.2.

- **22 to 44**— Persons in this age group represented 23.1 percent of the catchment area population in the national data and 38.4 percent of new patients. For the 10 centers, the group represented 25 percent of the population and 40.7 percent of new patients. The group's level of overrepresentation in the national figures and in the 10 center figures is nearly the same.

- **45 to 64**— The national data show that the age group made up 20.1 percent of the catchment area population and 15.1 percent of new patients. Data for the 10 centers show a 19.7 percent representation among the catchment area population and 15.1 percent of the new patients. The disparity for the national data is a negative 5 percent, whereas the disparity for the 10 centers is a negative 4.6 percent.

- **65+**— Older persons were also better represented among patients in the 10 centers than among the 328. Whereas they comprised 4.1 percent of new patients for the 328 centers, they made up 6.9 percent of the 10 centers visited.

Age specific addition rates for the 10 centers were also examined and are set forth in table 2.15. (Three of the centers visited by Commission staff were not included in either set of data. How much, if at all, their inclusion would alter the figures cannot be determined. During interviews at the Ravenswood Hospital Medical Center in Chicago and the Jackson Mental Health Center in Jackson, Mississippi, the directors provided data to staff which are reported below. With respect to the third center, Northwest Denver Community Mental Health Center, the director provided some data at the Denver hearing, which are also reported later in this chapter.)

Data for the Bexar County Southeast Center show that the addition rates for those under 15 and 45 to 64 fall short of the rate for all ages. Older persons have the highest rate with those 45 to 64 showing the lowest. Bexar County Southwest Center shows rates for the under 15 and 15 to 24 age groups that are lower than the rate for all ages. The addition rates for those under 15 and those 65 or over for the Edgewater-Uptown Center are about one-half the rate for all ages. The rate for those 45 to 64 also falls short of the aggregate rate.

Kennebec Valley Mental Health Center shows that the rate for older persons is nearly one-third that for all ages. The age groups under 15 and 45 to 64 also have low rates. Older persons have a rate equal to less than one-fourth the rate for all ages in the Highline-West Seattle Community Mental Health Center, with the age group under 15 following closely behind. The rate for those 45 to 54 is only about half that for all ages. Those 15 to 24 and 25 to 44 have rates that exceed the rate for all ages.

Data for the Park East Comprehensive Mental Health Center show that the rates

Table 2.15

Patient Addition Rates Per 100,000 Catchment Area Population for 10 Community Mental Health Centers, 1975

Centers	**Addition Rates**					
	All Ages	**Under 15**	**15-24**	**25-44**	**45-64**	**65 +**
Bexar County MR/MH Center, Southeast, Tex.	936.3	898.4	1047.8	989.0	624.2	1407.1
Bexar County MR/MH Center, Southwest, Tex.	511.6	305.4	435.7	730.7	714.4	1041.9
Edgewater Uptown CMHC, Chicago, Ill.	711.7	360.0	1105.1	991.7	665.2	349.2
Kennebec Valley MH Center, Maine	1416.3	1013.4	2135.5	2356.9	923.2	544.2
Highline-West Seattle CMHC, Wash.	551.5	150.4	989.9	1075.0	284.2	130.6
Tri-County CMHC, Mo.	1334.7	519.5	2261.5	1753.8	1361.5	1021.3
Park East Comprehensive CMHC, Colo.	553.8	169.9	876.4	1034.2	373.1	31.7
Westside CMHC, SFO	2058.1	925.0	2824.5	3603.8	1003.1	441.4
Southeast CMHC, SFO	1000.3	574.1	1238.0	1747.5	508.2	1180.7
Jackson Memorial Hospital, Miami, Fla.	1447.4	395.7	1880.3	2373.1	1428.8	1400.7

Source: U.S., Department of Health, Education, and Welfare, National Institute of Mental Health, Division of Biometry, and Epidemiology, Survey and Reports Branch, unpublished data.

for older persons is 17 times less than the rate for all ages. Those under 15 and those 45 to 54 also have rates substantially below the aggregate rate.

The addition rate for all ages in the Westside Community Mental Health Center is more than four times the rate for those 65 or over; more than twice the rate for those 45 to 64; and nearly twice the rate for those under 15. Data for the Southeast Community Mental Health Center indicate that those under 15 and those 45 to 64 have a rate just over one-half of the rate for all ages. In this center, the rate for older persons exceeds by a slight margin the aggregate rate, while those between 15 and 24 and those 25 to 44 have rates that well exceed the aggregate.

Finally, the Jackson Memorial Hospital Center data show that the rate for all ages is nearly four times that for those under 15. Those 45 to 64 and 65 or over also have rates lower than the aggregate but not substantially lower. The rates for those 15 to 24 and 25 to 44 substantially exceed the aggregate rate.

In summary, the addition rates for those under 15 are in every instance below a center's rate for all ages. For those 15 to 24 and those 25 to 44 the opposite is true—their addition rates in every case exceed the rate for all ages. Those 45 or over have rates in eight centers that fall short of the rate for all ages. The same is true for those 65 or over in seven centers.

The remainder of this section presents additional data on age participation in the community mental health centers program and a summary of information about the needs of certain age groups for mental health services. The "additional data" include information either obtained from center officials during the field study or extracted from their grant applications that were made available to Commission staff by NIMH. In some instances, the data reported below differ from what are considered to be the official data that have been presented in the preceding tables. The fact of the conflict and the immediate source of the data were considered to be of sufficient importance to include the information, nonetheless.

The Task Force on the Texas Department of Mental Health and Mental Retardation Services to Older Adults reported in 1976 that older persons were generally underrepresented in that State's mental health outpatient system. In 1974, 50.3 percent of persons in need aged 18 to 64 received services available from the department; only 13.0 percent of those in need aged 65 or over were served. The report also notes that older persons represented, on the average, 4 percent of the patient population of the State's community mental health centers but 10 percent of the general population. Data presented in the report indicate that the percentage of patients 65 or over may be as low as 3.6 percent. The report acknowledges that older persons receive some services under the State's mental health care system, but asserts that they are treated differently compared to others in the population. Specifically, older persons are "overrepresented in the institutional populations and dramatically underrepresented" in the community mental health center outpatient population.[62]

The Ravenswood Hospital Community Mental Health Center in Chicago, Illinois, noted in its 1976 grant application to NIMH that, except for children, adolescents, and older persons, the age characteristics of the patient population "closely approximated" those of the catchment area's general population.[63] A marked increase in services to children and adolescents resulted from the institution of a special program targeted at this group.[64] Persons 65 or over were underrepresented, a problem recognized by the center in that consultation and education activities were stepped up to reach them. The center expected this to result in a greater number of requests from older persons (and thus participants) for direct services in 1976.[65]

The 1976 application and related materials for the Tri-County Community Mental Health Center, North Kansas City, Missouri, point out that children "could be considered" to be underserved in the center's provision of direct services, while older persons (65+) are "relatively well represented" in the center's patient caseload.[66] Table 2.16 presents the data included in the center's application to support its conclusion. The data show that persons under 15 are seriously underrepresented in the aggregate and for each subgroup of the aggregate. Persons 55 or over are underrepresented in the same way. Persons between ages 15 and 44 are overrepresented as a single age group and by each subgroup to varying degrees. Based on these usage statistics, the center concludes that "the level of direct services provided to the elderly are adequate."[67] The application does point out, however, that the center will maintain and expand its efforts on behalf of older persons.[68] With respect to services to children, the center indicates an intent to institute specialized efforts to reach this age group more effectively.[69]

The Highline-West Seattle Community Mental Health Center in Seattle, Washington, indicated in its 1976 application for Federal funds that a local community needs assessment revealed that of the catchment area's population identified as "at-risk," 39 percent were youth and 10 percent were older persons.[70] Data included in the center's application showed that of the total served in 1975, about 3 percent were over 64 and nearly 12.1 percent were under 18. These figures are significantly

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[62] Austin, Texas, Department of Mental Health and Mental Retardation, *Report of Task Force on TDMHMR Services to Older Adults* (1976), p. 7 (hereafter cited as *Report of Task Force*).

[63] Chicago, Illinois, application for Federal community mental health center funds, 1976, Ravenswood Hospital Community Mental Health Center, p. 77.

[64] Ibid.

[65] Ibid., pp. 77–78.

[66] North Kansas City, Mo. application for Federal community mental health center funds, 1976, Tri-County Community Mental Health Center, appendices F and G (hereafter cited as Tri-County Application).

[67] Ibid., appendix F. Also, note that this statement contrasts with statements of center staff who, in interviews with Commission staff, indicated that the center was not serving as many older persons as it could. Jack Viar, Director,Tri-County Community Mental Health Center, interview in No. Kansas City, Mo., Apr. 13, 1977.

[68] Ibid.

[69] Ibid., appendix E.

[70] U.S., Commission on Civil Rights, staff summary, application of Highline West Seattle Community Mental Health Center, p. 2 (Commission files).

Table 2.16
Percent Distribution of Tri-County Community Mental Health Center Patients And the Catchment Area Population by Age

Age Group	Catchment Area Population		Patients	
All Ages	100.0%		100.0%	
0-4	8.8	30.5	0.3	13.9
5-9	10.9		4.6	
10-14	10.8		9.0	
15-19	8.9	43.8	17.4	66.0
20-24	7.4		12.4	
25-29	8.1		11.7	
30-34	6.8		9.3	
35-39	6.2		7.7	
40-44	6.4		6.5	
45-49	6.3		6.3	
50-54	5.0		6.2	
55-59	4.1		2.0	
60-64	3.3		2.0	
65-69	2.4	7.1	0.8	4.5
70-74	1.8		2.6	
75-79	1.3		0.7	
80-84	0.9		0.4	
85+	0.7		0.0	

Source: Application for Federal Community Mental Health Center Funds, Tri-County Mental Health Center, North Kansas City, Mo. (1976) Appendix F.

below their representation in the "at-risk" population.[71] The center's 1977 application showed a 1 percent decrease of participants under 18 and an increase of 1 percent with respect to those 65 or over. These were below revised "at-risk" population figures of 39 percent and 11 percent, respectively.[72]

The 1976 conversion grant application for the Bexar County Southwest Mental Health/Mental Retardation Center in Austin, Texas, indicated that at least 10 percent but possibly 17 percent of the older persons in the catchment area were in need of mental health services.[73] The application states further that 1 percent of its patients were 65 or over in fiscal year 1974 but 7.8 percent in fiscal year 1975.[74] The 1976 *Annual Report of the Bexar County Mental Health/Mental Retardation Center*, however, indicates that between September 1975 and August 1976 persons aged 65 or over accounted for 4.2 percent of the patient population.[75] With respect to services to young persons (under 19), the application indicates that 48 percent of the catchment area population falls within this age group.[76] The 1976 *Annual Report* indicates that this age group made up about 25 percent of the patients served between September 1975 and August 1976.[77]

The 1976 application of the Bexar County Southeast Mental Health/Mental Retardation Center indicates that those aged 19 or under make up 40.6 percent of the catchment area population; those 20 to 64, 40.6 percent; and those 65 or over, 19 percent.[78] Services data in the application indicate that those aged 18 or under make up 49 percent of the patient population; those 19 to 64, 40 percent; and those 65 or over, 11 percent.[79] The 1976 *Annual Report* (see above) shows that those under 19 made up 30 percent of the patients served between September 1975 and August 1976 and those aged 65 or over, 8.9 percent.[80]

The data reported here for the Southwest and Southeast centers vary from that reported in table 2.14. This may be a function of the time periods covered by each set of data. If so, there appear to be significant monthly fluctuations in the patients admitted to the centers.

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[71] Seattle, Washington, application for Federal community mental health center funds, 1976, Highline-West Seattle Community Mental Health Center, p. 13.

[72] Seattle, Washington, application for Federal community mental health center funds, 1977, Highline-West Seattle Community Mental Health Center, pp. 125, 131.

[73] San Antonio, Texas, application for Federal community mental health center funds, 1976, Bexar County Southwest Mental Health/Mental Retardation Center (hereafter cited as Bexar County Southwest Application).

[74] Ibid.

[75] San Antonio, Texas, Bexar County Mental Health/Mental Retardation Center, *1976 Annual Report*, p. 13 (hereafter cited as *1976 Annual Report*).

[76] Bexar County Southwest Application.

[77] *1976 Annual Report*, p. 13.

[78] San Antonio, Texas, application for Federal community mental health center funds, 1976, Bexar County Southeast Mental Health Center.

[79] Ibid., attachment I, p. 11. It should be noted that the patient data and population data presented are categorized in such a way as to make impossible direct comparison of patient to general population for those aged 19. Thus, the population data for age 19 are grouped with the younger age category; for patient data, age 19 is grouped with the next higher age grouping. It is not expected that significant percentage deviations would occur if the data had been presented to place those age 19 in the same category for each classification.

[80] *1976 Annual Report*, p. 13.

Data included in the application of the Jackson Mental Health Center, Jackson, Mississippi, indicate that for the period January through April 1975, 19 percent of the total patients were aged 19 or younger; 50 percent were 20 to 44; 23 percent, 45 to 54; and 8 percent, 65 or over.[81] These data seriously conflict with information provided to Commission staff by the center's coordinator of geriatric services who said that only 2 percent of the center's patients are older persons.[82]

With respect to the indirect services of community mental health centers—consultation and education—older persons receive substantially fewer benefits than any other age group. The Community Mental Health Centers Act provides that one objective of consultation and education services is to make residents of the service area aware of mental health problems and inform them of the types of services available.[83] NIMH refers to consultation and education services as the "preventive arm" of the program designed to reach and assist at-risk populations through intermediate agencies, organizations, and facilities concerned with their needs. Older persons and children have been identified as at-risk populations.[84]

NIMH reports that in 1976, 528 centers directed nearly 36 percent of their staff hours for consultation and education to agencies concerned primarily with children. Only 5 percent of their staff hours were devoted to agencies dealing with older persons. The remaining staff hours were distributed across functional as opposed to age-based agencies.[85] In one sample month (February 1976), 42 percent of total staff hours were devoted to schools, facilities, and other agencies concerned with children.[86] Only 4.9 percent of staff hours for consultation and education were devoted to agencies concerned with older persons.[87] Although efforts are being made on behalf of children who are underrepresented in the direct services population, little effort is being conducted on behalf of the older population.

Older persons are at a severe disadvantage when centers fail to work with agencies concerned primarily with their needs: (1) older persons do not have the opportunity to learn what preventive measures they can take to maintain good mental health or what signs to look for that may indicate problems; (2) older persons are less likely to learn about services available to them when they do encounter problems; (3) agencies concerned with older persons do not obtain the information and guidance necessary for them to provide appropriate and adequate assistance to older persons who may have mental health problems.

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[81] Jackson, Mississippi, application for Federal community mental health center funds, 1976, Jackson Mental Health Center, table 1.

[82] Sue Anne Meng, interview in Jackson, Miss., Apr. 25, 1977 (hereafter cited as Meng Interview).

[83] 42 U.S.C. §2689(b)(1)(D)(ii)(III) (Supp. V 1975).

[84] *Community Mental Health Centers*, p. 31. See also *Health Revenue Sharing Act*, pp. 57–58.

[85] Ibid., p. 24.

[86] Ibid., pp. 31, 32. See also note 19, p. 40.

[87] Ibid., p. 32.

The mere underrepresentation of older persons in community mental health centers gains greater significance when viewed against expert opinion and studies on mental health problems among persons aged 65 or over that indicate their substantial need for mental health services.

Dr. Gene Cohen, Director of the Center for the Study of the Mental Health of the Aging of NIMH, estimates, based on his work, that 18 to 25 percent of those 65 or older have mental health problems that interfere severely with their ability to function on a daily basis. He estimates further that of those persons 65 or over estimated to be in need of mental health care, the needs of 80 to 85 percent are not being met.[88]

According to the Commission on Mental Health appointed by President Carter, "the incidence of mental health problems is higher among people 65 and older than in other age groups." The Commission adds that "estimates indicate that 20 to 30 percent of all people labelled as 'senile' have conditions that are either preventable or reversible if detected and treated early."[89]

In a November 1970 report, the Committee on Aging of the Group for the Advancement of Psychiatry, relying in part on an NIMH study reported by the World Health Organization, noted that "psychopathology in general and depression in particular rises with age."[90] Table 2.17 presents the results of the NIMH study.[91]

The American Psychological Association has estimated that at least 3 million older persons or 15 percent of the older population require mental health services.[92] Robert Butler and Myrna Lewis believe that the association's estimate understates the real need. In their book *Aging and Mental Health*, the authors comment:

> A million older people are at this moment in institutional settings, for a variety of reasons. The effects of institutionalization itself ensure further emotional problems on top of those already existing. At least 2 million people living in the community have serious chronic disorders, predominantly physical but also mental. It is evident that the majority of people having chronic physical illness also have associated emotional reactions requiring attention. In addition are those persons who need treatment for primary mental illnesses. Added to this list are the 7 million who live below or near the official poverty level in conditions that are known to contribute to emotional breakdown or decline. Finally, the effects of lowered social status and self-esteem take a toll on mental health. Thus the

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[88] Dr. Gene Cohen, telephone interview in Wash., D.C., Oct. 27, 1977.

[89] *Preliminary Report of the President's Commission on Mental Health* (1977), p. 6 (hereafter cited as the *Preliminary Report of the President's Commission*).

[90] Group for the Advancement of Psychiatry, Task Force on Aging, *Toward a Public Policy on Mental Health Care of the Elderly* (New York: Group for the Advancement of Psychiatry, 1970), pp. 657–58.

[91] Ibid., p. 658. Also cited in Butler, *Why Survive?*, p. 227.

[92] American Psychological Association Task Force on Aging, "Proposed Recommendations," in *Mental Health Care and the Elderly*, appendix 1, item 3, p. 164.

Table 2.17
Incidence of New Cases of Psychopathology by Age

Age Range	New Cases Per 100,000 Population
Under 15	2.3
25-34	76.3
35-54	93.0
65+	236.1

Source: National Institute of Mental Health Study, reported in Group for the Advancement of Psychiatry, *Toward a Public Policy on Mental Health Care of the Elderly* (1970), p. 658

true proportion of psychiatric need among older people has not been fully documented.[93]

Older persons' need for mental health care is also suggested by their numbers among residents of mental institutions. Although older persons represented about 10 percent of the population in 1974, they accounted for 25.4 percent of the resident patients in State and county mental hospitals.[94] Older persons also acccount on an annual basis for 25 percent of all reported suicides,[95] well above their representation in the population.

Referring to much of the same data cited above, NIMH acknowledges in its *Forward Plan for Fiscal Years 1977–83* that older persons are particularly vulnerable to mental health problems: "the incidence of psychopathology, in general, and depression in particular, rises with age."[96] Adequate or appropriate care is not currently made available to them: "those over 65 occupy almost three times their proportionate share of all public mental health hospital beds," while "fewer than four percent of those seen in public clinics and less than two percent in private settings are over 65."[97]

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[93] Robert N. Butler, M.D. and Myrna Lewis, *Aging and Mental Health* (St. Louis: C. V. Mosby, 1977), 2nd ed., p. 52.

[94] Ibid., citing National Institute of Mental Health *Statistical Note 112.*

[95] *Preliminary Report of the President's Commission*, p. 6; and Butler, *Why Survive* ?, p. 228.

[96] U.S., Department of Health, Education, and Welfare, Public Health Service, Alchohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health, *Forward Plan : Fiscal Years 1977–83* (1977), pp. 9–10, 37, (hereafter cited as *Forward Plan*).

[97] Ibid.

The mental health needs of children and the failure of an adequate response also have been cited. The President's Commission on Mental Health reported: "According to the best recent estimates, 8.1 million of the 54 million children and youth of school age, or 15 percent of that population, need help for psychological disorders."[98] The President's Commission also cites the high incidence of child abuse and notes that adolescents show an alarming increase in suicide, depression, and alcohol and drug misuse.[99]

A report of the Joint Commission on Mental Health of Children pointed out:

> Our inadequate statistics show that 10 to 12 percent of our children and youth have psychological problems. Unknown numbers are falling far short of their developmental potential. In addition, there are the all too common problems of teen-age illegitimacy, venereal disease, drug use, youth unemployment. . . .
>
> The existing services for children and youth are inadequate. . .Mental health services exist for only about 7 percent of the identified population in need. . . .[100]

The Joint Commission also reported that although "the basis for mental development and competence is largely established by the age of six, emotional, mental, and behavioral disorders among infants and young children usually go unchecked until the child enters formal schooling. By this age, effective remediation is often difficult, if not impossible."[101]

The NIMH *Forward Plan*, referring to the needs of children, notes that conservative estimates indicate that less than 10 percent of the approximately 7,022,000 persons under age 18 in need of mental health care are being served.[102]

Parental Consent

At five of the nine States that Commission staff visited as part of the field study and in connection with the public hearings, community mental health center directors or staff members said their States' requirement that minors may not receive mental health services without the consent of a parent or guardian was a problem in serving children and adolescents adequately.

Staff of both the Ravenswood Hospital Medical Center and the Edgewater-Uptown Mental Health Center in Chicago, cited Illinois' parental consent requirement as a problem but did not specify the age restrictions involved.[103] Edgewater-Uptown center staff suggested, however, that the parental consent age be lowered to 15.[104]

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[98] *Preliminary Report of the President's Commission*, p. 5.

[99] Ibid.

[100] *Joint Commission Report*, p. 21.

[101] Ibid., pp. 5, 29.

[102] *Forward Plan*, p. 10.

[103] Dennis Kepchar, assistant center director, and staff, Ravenswood Hospital Medical Center, interview in Chicago, Ill., May 16, 1977 (hereafter cited as Kepchar Interview); Carlos Plazas, Director, and staff, Edgewater-Uptown Community Mental Health Center, interview in Chicago, Ill., May 17, 1977 (hereafter cited as Plazas Interview).

[104] Plazas Interview.

The coordinator of children's services for the Mississippi Department of Mental Health said, also without specifying an age, that parental consent requirements posed a problem in serving children and adolescents, particularly for teenagers with drug or drug-related problems who do not wish to have their parents learn of their problems. She added that the department was supporting a bill that was before the State senate when Commission staff visited Mississippi, which would permit physicians to treat minors aged 15 years or older without parental consent.[105]

The director of the Jackson Mental Health Center also cited parental consent requirements as creating a difficulty in providing services to those between the ages of 12 and 18 who may need services but wish to keep the information from their parents.[106]

Staff of the Tri-County Community Mental Health Center in North Kansas City, Missouri, said that State law forbids their treating individuals under 21 without parental consent. According to the staff, young persons with drug problems or venereal disease may, however, be treated.[107] (Missouri has since changed its consent laws. See discussion below.)

The Director of the outpatient department of the Highline-West Seattle Community Mental Health Center in Seattle, Washington, cited the State's law prohibiting treatment of persons under 14 without parental consent as a central problem in getting services to children.[108]

Testimony was given at the San Francisco hearing that California's parental consent requirements affected services to children.[109]

In all of the States visited by Commission staff, a State statute dictates the age of consent for medical services. California, Texas, Colorado, Illinois, Florida, Maine, Missouri, and Washington use age 18, and Mississippi uses age 21 as the general age of consent for medical services. All but Maine and Florida permit consent by married minors.[110] Four States allow consent by emancipated minors—at age 15 in Colorado and California, at age 16 in Texas, and at any age in Mississippi. Five States permit a minor to consent to treatment for drug abuse—at age 12 in Illinois and California, at age 13 in Texas, and at any age in Colorado, Maine, and Missouri.[111] Some of the State laws provide for other exceptions to the general parental consent requirements.[112]

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[105] Linda Raff, coordinator of children's services, Department of Mental Health, interview in Jackson, Miss., May 3, 1977 (hereafter cited as Raff Interview).

[106] Robert Mabry, director, Jackson Mental Health Center, interview in Jackson, Miss., Apr. 25, 1977 (hereafter cited as Mabry Interview).

[107] Robert Bruyn, coordinator, youth services, Tri-County Community Mental Health Center, interview in North Kansas City, Mo., Apr. 12, 1977 (hereafter cited as Bruyn Interview).

[108] Yvonne Owens, director, Outpatient Department, Highline-West Seattle Community Mental Health Center, interview in Seattle, Wash., Apr. 27, 1977 (hereafter cited as Owens Interview).

[109] Martha Roditti, social work lecturer, San Francisco State University, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California,* June 27-28, 1977, vol. I, p. 108 (hereafter cited as *San Francisco Hearing*).

[110] Calif. Civ. Code § 25.1, 25.6, 25.8 (West Supp. 1978); Colo. Rev. Stat. § 13-22-101(1)(d), 13-22-103 (1973); Fla. Stat. Ann. § 743.07 (Harrison Supp. 1977), § 381.382(5) (Harrison 1975); Ill. Ann. Stat. ch. 3 §131, ch. 91 § 18.1, 18.2 (Smith-Hurd Supp. 1978); Me. Rev. Stat. tit. 1 § 73 (Supp. 1976); Miss. Code Ann. § 1-3-27, 41-41-3 (1972); Mo. Ann. Stat. § 431.061 (Vernon Supp. 1978); Tex. Fam. Code Ann. tit. 2 § 11.01(1), 35.03 (Vernon 1975); Wash. Rev. Code Ann. § 26.28.015(5), 26.28.020 (Supp. 1976).

Reliance on Historical Patterns

Program participant data show that underservice to children and older persons has characterized the community mental health centers program for many years. The field study and testimony received at the Commission's public hearings demonstrated that a continuing reliance on historical service delivery patterns that excluded or limited services to these age groups has contributed to the current situation.

The American Psychiatric Association's 1971 report, entitled *Study of Mental Health Services for Children*, cited several reasons to explain its finding of inadequate services to children. "Important among them," according to the report, "is that many centers were disposed to concentrate their initial efforts in the area where they felt they could best demonstrate their greatest usefulness, namely, with emotionally disturbed adults."[113]

Testimony at the Commission's hearing in Denver confirmed the finding of the association. James Dolby, director of the Division of Mental Health in the Colorado State Department of Institutions, testified that in his judgment one of the most important factors in underservice to children and older persons concerns the "history of the development of the mental health center movement." He said that the early days of the program were geared to the needs of the general adult population, and what evolved was a program that served children infrequently and older persons virtually not at all.[114]

Dr. Carol Barbeito, director of the Colorado State Mental Health Association, testified that the community mental health center and mental health clinic movement responded to those who "walked in off the street"—which typically meant adults. She added that the clinicians originally hired to work in the program were more comfortable serving the adult population.[115]

James Noble, a gerontology program specialist with the Florida Department of Health and Rehabilitative Services, suggested that centers' reliance on the original "building-oriented model, a single location center type of thing," has interfered with designing a service program tailored to meet the needs of older persons.[116]

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[111] Calif. Civ. Code § 34.6, 34.10 (West Supp. 1978); Colo. Rev. Stat. § 13-22-102, 13-22-103 (1973); Ill. Ann. Stat. ch. 91 § 18.4 (Smith-Hurd Supp. 1978); Me. Rev. Stat. tit. 32 § 3292 (Supp. 1973); Miss. Code Ann. § 41-41-3(g) (1972); Mo. Ann. Stat. § 431.061.1 (4)(c) (Vernon Supp. 1978); Tex. Fam. Code Ann. tit. 2 § 35.03 (Vernon 1975), tit. 71 § 4447 (Vernon 1976).

[112] Calif. Civ. Code § 25.5, 25.7, 34.5, 34.7, 34.8, 34.9 (West Supp. 1978); Colo. Rev. Stat. § 13-22-105 (1973); Fla. Stat. Ann. § 743.06 (Harrison Supp. 1977); § 381.382 (Harrison 1975); Ill. Ann. Stat. ch. 91 § 18.3, 18.4, 18.7 (Smith-Hurd Supp. 1978); Mo. Ann. Stat. § 431.061 (Vernon Supp. 1978); Tex. Fam. Code Ann. tit. 2 § 35.03 (Vernon 1975).

[113] *Mental Health Services for Children*, pp. 15–16.

[114] James Dolby, testimony *Hearing Before the U.S. Commission on Civil Rights, Denver, Colorado.*, July 28–29, 1977, vol. I, p. 46 (hereafter cited as *Denver Hearing*).

[115] Dr. Carol Barbeito, testimony, *Denver Hearing*, p. 13.

The Commissioner of Maine's Department of Mental Health and Corrections said that although older persons and children should be served, a tendency to served the "best and the easiest" people has always existed. He added that "historically we have not wanted to serve the elderly but this is not true today."[117]

The interim director of the Division of Alcoholism, Drug Abuse, and Mental Health of the Department of Health, Education, and Welfare in Kansas City agreed that older persons and children under 15 were traditionally underserved in the community mental health centers program, but asserted that centers have had less difficulty in establishing services for children (except for those under 6) than for older persons. He explained that mental health services to children have historical precedents, both in terms of service delivery and personnel training, in child guidance clinics and family service associations that began in the 1940s. There have been no comparable historical organizational and training developments for older persons.[118]

The director of community services in the Missouri Department of Mental Health commented, "for years we've ignored children and the elderly because they're tough areas."[119]

Although the 1975 amendments require that to continue receiving funds centers will have to include specialized programs of services for children and older persons, Federal officials, State mental health agency directors, and center directors asserted, almost uniformly, that increased Federal funds would be necessary to implement the new requirements.

Outreach and Referral Activities

Three aspects of the centers visited in the field study and in connection with the public hearings were covered: (1) agency, program, or community centered outreach (consultation and education services); (2) client centered outreach; and (3) reliance on referral sources for clients.

Consultation and education services have been a required part of a community mental health center since the program's inception.[120] The 1975 amendments to the act significantly expanded the definition of such services.[121] They are intended to cover a wide range of activities designed to, among other things, "develop effective mental health programs in the center's catchment area," and to make catchment area residents aware of the "nature of mental health problems and the types of mental health services available." Consultation and education services are classified as "indirect services," in that center staff do not generally provide these services directly to patients but rather work through a variety of intermediate social and educational service providers and civic organizations, for example, schools, police, the clergy, and nursing homes.[122] NIMH indicates that consultation and education activities are directed to "at-risk" populations[123] and has included children, youth, and older persons, among others, within this grouping.[124] The importance of this service was underscored by the House Interstate and Foreign Commerce Committee:

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[116] James Noble, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida*, Aug. 22–23, 1977, vol. I, p. 152 (hereafter cited as *Miami Hearing*). The Community Mental Health Centers program was originally a construction program insofar as Federal funding was concerned.

[117] George Zitnay, interview in Augusta, Me., May 25, 1977 (hereafter cited as Zitnay Interview).

[118] Robert Battjes, interview in Kansas City, Mo., Apr. 13, 1977 (hereafter cited as Battjes Interview).

[119] Walter Conway, interview in Jefferson City, Mo., Apr. 14, 1977 (hereafter cited as Conway Interview).

[120] 45 C.F.R. §54.212 (Supp. 1967).

[121] 42 U.S.C. §2689(b)(1)(D) (Supp. V 1975).

> The service. . .can have a marked impact on the appropriate, effective utilization of the center and upon patient flow through the direct services. Through effective consultation and education, the center will receive more appropriate referrals, enable other caregivers to manage their clients more effectively, and enhance continuity of care, as well as *extending service to underserved groups* in the catchment area.[125] [Emphasis supplied]

Thus, consultation and education services, if effectively implemented, would serve as a primary means of reaching those persons in need who might not otherwise learn of the available services and who were underrepresented in the center's direct services populations. Two groups with great unmet needs identified by the Committee were "children and the aged."[126] The Committee also pointed out that a center "cannot serve as an effective community resource if large segments of the population are unaware of its purposes, its functions, its location, or its relevance to community needs."[127]

All centers visited by the Commission were performing some kind of consultation and education services; however, information obtained about the nature and extent of the centers' efforts during the field study helps explain the fact that, in 1976, only 5 percent of all staff hours spent on consultation and education services for 528 community mental health centers were devoted to older persons.[128] In addition, although most consultation and education activities were directed toward agencies and others concerned with children, it was pointed out at several sites that schools were the primary target,[129] which in some instances effectively left out those of preschool age. The director and staff of the Edgewater-Uptown Community Mental Health Center expressed some concern about not reaching those of preschool age, but said that this group may be receiving services from other community agencies. The director also pointed that, although services were concentrated on those in school, they were also very concerned about children "falling through the cracks" (particularly Hispanic children), who either had learning disabilities that the schools were not noticing or were droppinng out of school.[130]

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[122] *Community Mental Health Centers*, pp. 39–40.
[123] Ibid., p. 31.
[124] *Forward Plan*, pp. 9–10.
[125] *Health Revenue Sharing Act*, p. 58.
[126] Ibid., p. 45.
[127] Ibid., p. 60.
[128] *Community Mental Health Centers*, p. 24.
[129] Mabry Interview; Cheryl Cohen, director, Consultation and Education Services, Highline-West Seattle Community Mental Health Center, interview in Seattle, Wash., Apr. 27, 1977 (hereafter cited as Cohen Interview); Donald Seideman, executive director, Highline-West Seattle Community Mental Health Center, interview in Seattle, Wash., Apr. 27, 1977 (hereafter cited as Seideman Interview); Alan Wilcox, coordinator of community services, Tri-County Community Mental Health Center, interview in North Kansas City, Mo., Apr. 12, 1977 (hereafter cited as Wilcox Interview); Plazas Interview; Kepchar Interview; and Bruyn Interview.

It should be noted that some centers consider their consultation and education activities to be interchangeable with client-based outreach activities, while others consider these services to be independent of each other.

When Commission staff visited, one center had no consultation and education services directed toward agencies dealing with older persons. The director said that the center had previously provided such services to the city housing authority with regard to older persons who lived in the housing projects. Center staff's expectations that they would work with housing residents as well as the housing authority staff were never realized and the services were discontinued. The director pointed out that this incident highlighted for center staff the attitudes of service providers and how they can operate as barriers to serving older persons. He did not indicate, however, that the center had made any efforts to work with other age-based agencies, such as nursing homes or senior centers, which he acknowledged were operating in the community. He noted that there "are a lot of elderly out there, particularly in nursing homes, with problems like organicity and functional psychoses which could be managed well psychiatrically." He concluded, "There are a lot of elderly out there who could use the center's help."[131]

Despite the recognition of need, the center had no formal outreach program outside of the consultation and education services of the center, and, as indicated, none of these was specially directed toward older persons.[132] The director of geriatric services (who apparently had been appointed just before or on the day of the Commission's site visit and had been the social worker in the center's inpatient unit) said with respect to the needs of older persons: "We don't know where older people residing in the community live and what their needs are."[133] According to her, the center had never assessed older persons' needs, a task she planned to take on immediately with her new duties. The geriatric services coordinator also indicated, in contrast to the information set forth in the center's grant application which indicated that 8 percent of patients were older persons, that only 2 percent of its clients were older persons.[134] Program plans with regard to older persons were still unclear; the geriatric services coordinator had no idea what funds she would have to work with nor how such decisions were going to be made.[135] The director indicated that although coordinators for services to older persons and to children have been appointed (the children's coordinator had been appointed about the time Commission staff made the site visit appointment), he did not anticipate establishing new service units with expanded budgets.[136]

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[130] Plazas Interview.

[131] Mabry Interview.

[132] Ibid.

[133] Meng Interview.

[134] Ibid.

[135] Ibid.

The Tri-County Community Mental Health Center reported in its 1976 application for funds that only 5 percent of its consultation and education effort was being directed to agencies concerned with older persons.[137] The center's outreach activities are conducted as part of its Community Services Program. Components of this program include: radio interviews; publicity in local newspapers; mental health association workshops; referrals from friends/relatives; referrals from medical facilities, law enforcement agencies, clergy, and non-psychiatric physicians; presentations; tours of the center; and slide shows.[138] The community services staff is made up of two social workers, one psychologist, and a nurse. The center has designated children and older persons as target groups for special treatment by their Community Services Program. For older persons, the unit provides a widower/widow program, consultation with nursing homes, followup of geriatric patients, and is in the process of planning a pre-retirement program for businesses in the area. For children, the unit provides consultation with schools, parent-teen rap groups, and consultation with the Job Corps Center. The center is also beginning to work with a community task force on child abuse.[139]

Additonal information was later passed on to Commission staff to clarify further the consultation and education activities of the center insofar as older persons are concerned. In a memorandum to the center's director, the director of community services indicated the following:

> After a quick and informal survey, I learned that. .staff are involved as fairly regular consultant-collaborators with: 3 of the 4 Professional Nursing Homes, all of the 3 Practical Nursing Homes and about half (4 of 8) of the Boarding or Domiciliary Homes in the 3-county area. We are actively involved when our [patient] goes to, or comes from, one of these facilities, and we stay available if/when regular visits are no longer needed or desired.[140]

At the Ravenswood Medical Hospital center, outreach activities are conducted as part of its consultation and education effort and are administered by a separate unit within the center's structure.[141] The center has not designated any special groups for targeting its outreach program; however, the consultation and education unit represents the main vehicle through which any mental health services are provided to persons 60 years or older. Services provided include a widow/widower phone service, consultation with agencies and organizations serving the elderly, and seminars on aging issues. The widow/widower phone service is staffed by four volunteers who receive supervision biweekly from consultation and education staff. Since its inception in June 1975, 59 widows/widowers have been contacted through the phone service. Only

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[136] Mabry Interview.

[137] Tri-County Application, appendix F.

[138] Wilcox Interview.

[139] Ibid.

[140] Alan Wilcox, memorandum to Jack Viar, director, Tri-County Community Mental Health Center, undated.

[141] Kepchar Interview.

36 percent of this group has been 60 years of age or older. Consultation was also provided to the city's office of senior citizens and to a network of churches that provide social services to the elderly. The unit once provided weekly consultation to the nursing home in the catchment area, but this service terminated some time ago when the contract with the nursing home expired. The unit also received a grant from the city's office of senior citizens to do followup with elderly patients discharged from the hospital. This service was also terminated when the grant expired in September 1976.[142] It appears that such specialized consultation and education services are reliant on outside funding sources; when the source dries-up, the services are discontinued and not absorbed into the regular consultation and education program.

Center staff remarked that, based on a self-assessment of the effectiveness of their outreach efforts, the center appears to be reaching everyone in the community except the older population.[143] In addition, although the consultation and education unit has undertaken some activities on behalf of older persons, its efforts have not appeared to result in any change in the population's use of the center's direct clinical services. In fact, the center's staff reported that a decreasing number of older persons have used the center's inpatient service and day treatment programs in the past year. The HEW regional official with whom Commission staff spoke explained that efforts of the consultation and education unit and the clinical services unit are not integrated, so little, if any, change could be expected as a result of consultation and education efforts.[144]

When asked whether they perceived any age discrimination in the operation of their program, center staff responded affirmatively saying that older persons are discriminated against as a result of the center's not reaching out to them. Staff said that once older persons entered the center they would be served, but that factors such as lack of transportation, lack of outreach, lack of coordination with other agencies serving older persons, and the lack of knowledge on the part of staff about the problems of older persons produce underservice to this age group.[145]

Despite assertions in the center's 1976 application that patient demographic characteristics closely approximated those of the area's population (see Program Participants Section above), center staff said that while older persons represent 23 percent of the catchment area population, they make up 3.2 of the center's patient population.[146]

At the Edgewater-Uptown Community Mental Health Center, where consultation and education activities also encompassed some personal outreach, center staff cited a tremendous need for significantly expanding their outreach efforts. They informed Commission staff that many isolated elderly lived in the area and the center's current outreach efforts were "barely skimming the surface." Although 3,200 older persons, or 22 percent of the general population, reside in the area, center staff said their average older caseload per month was 80 persons.[147] Staff also indicated that older persons are generally an "invisible" group, meaning that their needs are not readily apparent to the community, unlike the "squeaky wheel" (one who complains loudest or most frequently) who gets the attention. As a result, a more active effort to reach older persons in the community is recognized by staff as necessary, but the center lacks the funds to mount such efforts. Staff pointed out that the State Department of Mental Health does not regard outreach as a function of a community mental health center and consequently makes no funds available for such purposes. The director offered as proof that outreach works, the increased number of referrals from schools because of the center's increased activity in this area.[148]

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[142] Ibid.

[143] Ibid.

[144] Martin Keeley, regional representative for community mental health centers in Illinois, Department of Health, Education, and Welfare, interview in Chicago, Ill., May 19 1977 (hereafter cited as Keeley Interview).

[145] Kepchar Interivew.

[146] Ibid.

The consultation and education services of the Kennebec Valley Community Mental Health Center operate mainly through the school system. Center staff said, however, that the "two best services" for older persons were outreach and psychiatric screening at senior centers or similar places. It was said that the invisibility of the older population in the rural State was compounded by the lack of transportation. The outreach or consultation and education services with respect to older persons were very limited. The center has a contract with the Diocesan Bureau of Human Relations Services to perform some outreach; however, the center director noted that outreach is provided once the person has been identified by another system such as the general hospital. The isolated older person is generally not reached by the outreach program and thus neither by the center. The director indicated that in the past the center did have an outreach program for older persons living alone. This program "fell apart" because there was no one to oversee it, and since then no funds have been available to reinstitute the effort.[149]

The coordinator of geriatric services for the Bexar County Mental Health Center-Southeast, said that in his view outreach efforts are not reaching the older population. He also indicated that an internal policy of the center was to discourage outreach services because it was not counted as a direct service.[150] The director of the Center, however, indicated that older persons had been designated as a special group for purposes of the center's outreach activities. He noted that the center was working with the nursing homes in the area and coordinating its efforts for older persons with the Bexar County Southwest Center.[151]

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[147] Plazas Interview.

[148] Ibid.

[149] Carmen Celenza, director, Kennebec Valley Mental Health Center, interview in Waterville, Me., May 24, 1977 (hereafter cited as Celenza Interview).

[150] Dr. Noel Laurel, coordinator of geriatric services, Bexar County Mental Health/Mental Retardation Center- Southeast, interview in San Antonio, Tex., Apr. 26, 1977 (hereafter cited as Laurel Interview).

[151] Dr. Harold Jones, project director, Bexar County Mental Health/Mental Retardation Center-Southeast, interview in San Antonio, Tex., Apr. 26, 1977 (hereafter cited as Jones Interview).

A Federal official in Kansas City commented that the center program is designed to serve those more easy to reach—those who come in for services. The lack of mobility and isolation that characterize many older persons, he said, make it difficult if not impossible for them to obtain services.[152]

Four Federal regional office officials cited the relative isolation of the elderly and the need to respond with some form of outreach services. Two officials in the Seattle office indicated that outreach was a necessary service, especially for young children and older persons. They said that about 3 or 4 years ago, "there had been a real push on" outreach but that with tighter resources and the costs involved, there is little "payoff" for a center to provide outreach when there are insufficient resources, when staff are not necessarily comfortable treating the people to whom outreach would be directed, and when outreach is not a fee-generating activity.[153]

A regional official in Boston also noted, among other things, that older persons are hard to reach because of their isolation from the mainstream of the community and that this suggested the importance of consultation and education services and outreach services.[154]

In fact, inadequate outreach and lack of transportation were cited at virtually all centers visited as part of the field study to explain in part their underservice to older persons.[155] Staff of two centers emphasized the particular transportation difficulties confronting older persons in their areas, where centers were located on the outskirts of town and the areas had limited public transportation.[156] Other centers' staffs also pointed out transportation as a problem.[157]

Despite the fairly uniform recognition that outreach services were necessary but lacking, few centers indicated any plans for expanding or establishing such a program. Program administrators offered the following reasons for not providing outreach: (1) they were operating at capacity and any outreach efforts would bring in more clients than could be served; (2) they were reluctant to direct resources to outreach activities; (3) they lacked the resources and the personnel to mount effective outreach programs; (4) they did not view outreach as part of their responsibility, because it was not a reimbursable service.[158]

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[152] Robert Battjes, interim director, Division of Alcoholism, Drug Abuse, and Mental Health, interview in Kansas City, Mo., Apr. 13, 1977 (hereafter cited as Battjes Interview).

[153] John Bartleson, director, Division of Alcoholism, Drug Abuse, and Mental Health, and Norma Baxter, mental health program consultant, interview in Seattle, Wash., Apr. 28, 1977 (hereafter cited as Bartleson-Baxter Interview).

[154] Martin Feldman, regional program consultant on alcoholism, drug abuse, and mental health, interview in Boston, Mass., May 26, 1977 (hereafter cited as Feldman interview).

[155] Kepchar Interview; Plazas Interview; Celenza Interview; Mabry Interview; and Jim Wintz, social worker, Highline-West Seattle Community Mental Health Center, interview in Seattle, Wash., Apr. 27, 1977 (hereafted cited as Wintz Interview).

[156] Wilcox Interview; Meng Interview.

[157] Celenza Interview; Wintz Interview; and Richard Marquez, project director, Bexar County Mental Health/Mental Retardation Center-Southwest, interview in San Antonio, Tex., Apr. 27, 1977. The Bexar County center, however, did have vans available for patient use.

The problem of scarce or nonexistent referral sources was also pointed out as a major problem that impeded the provision of services to both children (primarily under 5) and older persons. Staff of four centers indicated that children who are not yet of school age were underserved, since the children do not come in contact with the social and educational service networks.[159] The coordinator of youth services at one center indicated that the effectiveness of schools as a referral source is sometimes questionable. He said that in his area, there was an unwritten ban on teacher referrals because schools are concerned that they may be liable to pay for the treatment because of Federal laws requiring schools to educate the handicapped.[160] The director of another center said that it had taken 6 years to develop a working relationshop with the schools in her area because of their resistance to the center's program.[161] A Federal official in Boston while citing the lack of a referral system or process for preschoolers also cited resistance on the part of schools as an impediment to serving children.[162]

Similarly, several program administrators at the Federal, State, and local levels commented that older persons had little or no contact with the formal referral networks and this contributed to their underservice.[163] One Federal official summed up the problem by saying that older persons are not referred to centers as often or as easily as other age groups because they tend to be more isolated and have fewer points of contact with the traditional social and educational service networks, and are often less likely to refer themselves.[164]

Testimony received in the public hearings confirmed the information obtained through the field study.

Dr. Alexander Simon, a psychiatrist with the Southeast Community Mental Health Center in San Francisco, underlined the arguments that are given for not providing adequate outreach or transportation: "Many older persons are homebound and it is too costly, *it is said*, to provide transportation for them and too time-consuming to make home visits. . . ."[165] [emphasis supplied]

Dr. Carol Barbeito, director of the Colorado Mental Health Association, testified that outreach services are necessary to reach those whom centers have not been serving, but that such services are not being provided because "we can't handle it. . . .We are not really ready for new groups."[166]

Dr. Edmund Casper, director of psychiatric services for the City and County of Denver and director of the Northwest Denver Community Mental Health Cen-

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[158] Wilcox Interview; Mabry Interview; Seideman Interview; Plazas Interview; Kepchar Interview; and Celenza Interview.

[159] Plazas Interview; Celenza Interview; Bruyn Interview; and Kepchar Interview.

[160] Bruyn Interview.

[161] Celenza Interview.

[162] Feldman Interview.

[163] Zitnay Interview; Battjes Interview; Feldman Interview; Kepchar Interview; Plazas Interview; and Celenza Interview.

[164] Battjes Interview.

[165] Dr. Alexander Simon, testimony, *San Francisco Hearing*, p. 160.

[166] Dr. Barbeito Testimony, *Denver Hearing*, p. 23.

ter, was asked whether his center's program included an outreach program to increase the number of older participants. He responded that his center has contacts with agencies serving older persons and has attempted to identify those older persons now being treated by the center. He stated further, "We have no outreach system per se. We have no accurate recruitment of patients at this time."[167]

Dr. Larry Osaki, director of research and evaluation for the Denver Park East Community Mental Health Center, was asked the same question. He said that his center had "some outreach" directed toward nursing and boarding homes.[168]

According to Dr. Casper, 3 percent of the patients at the Northwest Center were 65 or over; according to Dr. Osaki, 1.2 to 1.5 percent, at the Park East Center.[169]

The Commission did learn of one center that had mounted an extensive outreach effort directed toward older persons, which appears to be successfully reaching this age group in spite of limited funds. Dr. Evalina Bestman, director of the community mental health program, Memorial Hospital at the University of Miami, hired a gerontologist who organized a group of volunteers to initiate an outreach program in the northwest corner of the center's community, where most of the elderly live in trailer courts. As a result of this outreach effort, a group was formed called the Neighborhood Family, Inc. They secured free quarters—a warehouse—in one of the local shopping centers near the trailer courts and solicited donations from the community to decorate it. Nurses, a psychiatrist, and a social worker were assigned to the group which now has 400 members. Volunteers continue to play a critical role in the project by keeping in touch with the elderly who live in the trailers and notifying center staff when someone is in need of psychiatric or medical care. Transportation is also available as well as a congregate meals program for center clients.[170]

James Noble, a gerontology program specialist with the Florida Department of Health and Rehabilitative Services, testified that the community mental health centers in the State's rural areas were operating outreach programs. He added his view, though, that age discrimination exists in the mental health area. Older persons who go to a center will be served, he said, but "since they do not come in, nobody is really going to go out after them."[171]

Cost and Cost-Effectiveness

Scarce resources and the high cost of serving older persons and children was a recurring theme in the field study and the public hearings. Scarce resources coupled with therapeutic pessimism about treating older persons successfully has led some centers to assess their resource distribution patterns in terms of the service benefits that might be lost to others who may be more easily helped.

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[167] Dr. Edmund Casper Testimony, *Denver Hearing*, p. 47.

[168] Dr. Larry Osaki Testimony, *Denver Hearing*, p. 47.

[169] Casper and Dr. Osaki Testimony, *Denver Hearing*, p. 47.

[170] Dr. Evalina Bestman Testimony, *Miami Hearing*, p. 160.

[171] Noble Testimony, *Miami Hearing*, p. 151.

Dr. Robert Dick, Community Mental Health Center Administrator for Florida of the U.S. Public Health Service in Atlanta, testified:

> I think that one of the biggest areas of discrimination in terms of age has to do with health economics—just the whole economic structure behind it and how health services are paid for. . . .
>
> When community mental health centers, administrators, and boards. . . .sit down to discuss health policies, everybody is more interested in how it is going to be paid for and whether they are going to get the money to pay for the services, rather than the actual need for the services. You cannot deny. . .that the elderly services would. . .constitute a higher-risk group, yet trying to convince policymakers that the present health economics structure would help pay for this service is difficult.[172]

The executive director of the Highline-West Seattle Center indicated that it is the belief of the members of his board that children and families should be served first because they are more cost effective.[173]

Although children and older persons have been designated as a priority by the State because of their prior underservice, the Commissioner of Maine's mental health agency indicated that adherence of the center to that priority would depend on the State's providing additional funds.[174]

In spite of the new requirements for programs of specialized services to older persons and children, one Federal official in Chicago predicted that few changes will result without new funds. He contended that the centers are aware that there are older persons in the communities who are not being served, but the centers do not want to go too far in establishing specialized programs for older persons for fear of getting "swamped."[175]

Staff of the Edgewater-Uptown Center, which has experienced several budget reductions in the past few years, said that any further budget cuts would be reflected first in cutbacks in services to age groups who cannot pay, that is, children and older persons.[176] The lack of funds was cited by staff as the largest problem the center has in serving older persons adequately. Comments made at this center were echoed in Maine at the Kennebec Valley Mental Health Center.[177] Several center officials also said that limited resources do not permit the provision of outreach services and home visits that are necessary to reach these age groups, particularly since such services are not reimbursable.[178]

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[172] Dr. Robert Dick Testimony, *Miami Hearing*, p. 154.

[173] Seideman Interview.

[174] Zitnay Interview.

[175] Keeley Interview.

[176] Plazas Interview.

[177] Celenza Interview.

[178] Seidemen Interview; Plazas Interview; Kepchar Interview.

Dr. William Pierce, executive director of the Westside Community Mental Health Center in San Francisco, testified:

> I would agree with the issue that money is certainly a problem. . . .
>
> . . .When you provide services to children and youth and to our senior citizen population, in many regards you are going to have to provide multiple services to this patient population because of the multiple problems that affect, for instance, the geriatric population in terms of health, social isolation, in addition to whatever mental health problems may directly affect them. . . .With children and youth, you have to deal with the interface of several human service systems, the school system, the court system, the mental health system. And when you begin to deal with complexities of interrelating large systems. . .then it becomes even more difficult to implement.[179]

Dr. Pierce expressed the belief, however, that centers could increase their ability to develop services for children and older persons even though funds may be limited. He suggested that centers needed to obtain greater input from their communities in setting priorities and that then they would begin to develop a sense of urgency about the problems that affect children, youth, and older persons.[180]

Dr. Alexander Simon, with the Southeast Community Mental Health Center, addressed a question about resource allocation decisions that operated against older persons based on the assumption that younger persons have more years to live and are more productive:

> This is a rationalization. . .that is used by people not to offer services to older people—that because they are old they don't have very much more to live and since we have limited amounts of money we are going to spend it on younger adults or on children. . . .[181]

Reliance on Age Categorical Programs

Commission staff encountered one situation in which age categorical programs were being relied on to substitute for services to older persons under general population based programs. This was described at the public hearing in Miami, Florida.

James Noble recounted the State's experience after establishing 13 specialized mental health projects for older persons in catchment areas having community mental health centers:

> . . .[W]e would put $80,000 into a catchment area that might have 37 or over 50 percent elderly people, and the response of the centers in many cases is, "Well, that project serves the older person. We at the center do not really have to be that much concerned. We have a special place for them to go."[182]

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[179] Dr. William Pierce Testimony, *San Francisco Hearing*, p. 163.

[180] Ibid.

[181] Dr. Simon Testimony, *San Francisco Hearing*, p. 161.

[182] Noble Testimony, *Miami Hearing*, p. 150.

He concluded that a regression of services to older persons actually results. The centers do not generally increase their services to older persons when the centers experience growth. Instead, they rely on the special project, which involves a comparatively small amount of funds.[183]

Staff Attitudes

Many community mental health center directors, directors of State mental health agencies, and Federal mental health officials said that negative staff attitudes toward older persons and, in some instances, toward children, contributed to their underrepresentation in the program.[184]

The director of one center reported to Commission staff that his center is placing less emphasis on older persons who are seen as simply needing an opportunity to use socialization skills that they have acquired. Thus, older persons' problems are related principally to the need for social services, not mental health services. He was asked if there were not situations where intervention by mental health professionals to assist older persons would be just as necessary as for other age groups (for example, depression following retirement). The director agreed that there might be such a situation where intervention should take place, but he went on to say that older persons are not as likely to come into a psychiatric clinic and could be better served by "getting them to a clergyman or by channeling them in some other direction such as a Rotary Club or going fishing."[185]

Dr. Abraham Kauvar, manager of health and hospitals for the city and county of Denver, referred to the YAVIS syndrome as influencing psychiatrists' preferences for patients: "Y is for young; A is for attractive; V is for verbal; I is for intelligence; and S is for self-serving."[186]

The 1974 report of the General Accounting Office in its study of community mental health services includes illustrative comments from officials of centers to explain the reasons for the underrepresentation of children and older persons in their programs, such as the following:

> Children and elderly persons are less desirable to work with because a highly specialized staff is needed to provide children's services and it is difficult to show success in treating elderly patients.[187]

The executive director and clinical director of one center informed Commission staff that therapists are uncomfortable with and reluctant to treat minimally verbal or nonverbal children—those under 12.[188]

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[183] Ibid.

[184] Owens Interview; Wintz Interview; Meng Interview; Battjes Interview; Feldman Interview; Zitnay Interview; Robert Anderson, director of community services, Illinois Department of Mental Health, interview in Chicago, Ill., May 18, 1977 (hereafter cited as Anderson Interview); Dr. Thomas Plaut, testimony, *Hearing Before the U.S. Commission on Civil Rights*, Washington, D.C., Sept. 26–28, 1977, vol. I, p. 238 (hereafter cited as *Washington, D.C. Hearing*); Dr. Robert Butler, testimony, *Washington, D.C. Hearing*, p. 12.

[185] Seideman Interview.

[186] Dr. Abraham Kauvar, testimony, *Denver Hearing*, p. 11. Others who have also referred to the YAVIS syndrome say that "s" stands for "successful." See, for example, Butler, *Why Survive?*, p. 233.

[187] *GAO Report*, p. 11.

Margaret Jacks, former director of Florida's State Office of Aging and Adult Services, testified about what she believed to be prevailing attitudes in mental health care that account, in part, for older persons' not getting proper treatment:

> They are saying: "The older person is getting old, so why should I waste my time on them? He is not going to live long anyway. I will spend my professional skill, my knowledge, and my time in treating. . .younger people who have longer to live, because what I have to give is worth too much to waste on somebody who is going to die pretty soon."[189]

In *Why Survive? Being Old in America*, Dr. Robert Butler, Director of the National Institute on Aging of the Department of Health, Education, and Welfare, described this same attitude:

> There is almost a Peter Pan sense that medicine should be immediately gratifying and not spoiled by situations which defy the doctor's ability to "make it all better." Yet the medical care of the old is more complex than that of the young. . . .[I]nherent in this is a greater challenge to the perceptions and intellect of physicians—if they can avoid the beguilement of "fast return" medicine.[190]

The report of the task force on the Texas Department of Mental Health and Mental Retardation Services to Older Adults lists "attitudes of care-givers" as a barrier to older persons' receipt of mental health care. The report goes on to say that "too often the unwarranted assumption of chronicity and untreatability coupled with a general lack of understanding of the aged and aging serves to systematically deny viable treatment options to the older adult."[191]

Dr. Thomas Plaut, Deputy Director of the National Institute of Mental Health, informed the Commission that one problem in providing mental health services to older persons is the fact that centers still tend to be staffed primarily by traditional mental health personnel who generally "partake of the therapeutic nihilism and pessimism," about services to older persons.[192]

Reasons underlying the negative attitudes toward treating older persons were offered in a 1971 report of the Committee on Aging of the Group for the Advancement of Psychiatry:

- The aged stimulate the therapist's fears about his own old age.
- They arouse the therapist's conflicts about his relationships with parental figures.
- The therapist believes he has nothing useful to offer old people because he

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[188] Seideman Interview; Dr. John Lavelle, clinical director, Highline-West Seattle Community Mental Health Center, interview in Seattle, Wash., Apr. 27, 1977.

[189] Margaret Jacks, testimony, *Miami Hearing*, p. 217.

[190] Butler, *Why Survive?*, p. 179.

[191] *Report of Task Force*, p. 8.

[192] Dr. Plaut Testimony, *Washington D.C. Hearing*, p. 238.

believes they cannot change their behavior or that their problems are all due to untreatable organic brain diseases.

- The therapist believes that his psychodynamic skills will be wasted if he works with the aged, because they are near death and not really deserving of attention.

- The patient might die while in treatment, which could challenge the therapist's sense of importance.

- The therapist's colleagues may be contemptuous of his efforts on behalf of aged patients.[193]

The director of Illinois' mental health agency told Commission staff that clinicians' reluctance to treat older persons stems from their training. Clinicians are trained to do psychotherapy and older people often need social services in addition to counseling. He commented further that training is needed to dispel the myths that older persons are not interesting to work with.[194]

Dr. Eric Pfeiffer, director of the Davis Institute on the Care and Study of the Aging, told the Commission that the provision of adequate training can go far in correcting attitudinal biases against older persons:

> . . .When we have had the opportunity to specially train mental health personnel in providing mental health services to the elderly, given them the skills, made them aware of the necessary attitudes, the attention to family matters, the attention to the necessary societal settings in which that older person survives, then the treatability, the responsiveness of the personnel becomes vastly different. They become positive about treating the elderly. They are successful in treating the elderly mentally ill. . . .[195]

Training

At five of the eight community mental health centers visited in the field study, center and State officials cited problems in finding staff with appropriate training to work with children and older persons as a reason for underservice to these age groups.[196] The need for inservice training to expand the capabilities of existing staff in this area was also raised as a necessary action.[197]

Not having adequately trained staff creates problems in accurately diagnosing an older person's mental health problems. Staff at one center said that the lack of adequate training, in their experience, has often resulted in misdiagnosis.[198] Dr. Robert Butler, director of the National Institute on Aging, also linked lack of adequate training with the probability of inaccurate diagnoses.[199]

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[193] Group for the Advancement of Psychiatry, *The Aged and Community Mental Health: A Guide to Program Development* (New York: Group for the Advancement of Psychiatry, 1971), p. 36.
[194] Anderson Interview.
[195] Dr. Eric Pfeiffer Testimony, *Denver Hearing*, pp. 20–21

[196] Plazas Interview; Kepchar Interview; Seideman Interview; Mabry Interview, Laurel Interview; Anderson Interview.
[197] Ibid.
[198] Kepchar Interview.

Several officials in the Department of Health, Education, and Welfare's regional offices described the difficulty of finding staff with expertise in aging and mental health as contributing to inadequate services for older persons.[200]

The failure of educational institutions to train personnel in aging and mental health was discussed at length by the former chairman of a California medical school curriculum committee. Dr. Alexander Simon, now with the Southeast Community Mental Health Center, testified that because of this lack of training, "psychiatrists, social workers, nurses, and other mental health personnel are not as interested in treating the aged as they are in younger patients."[201] Witnesses at all of the Commission's hearings commented on the lack of trained mental health personnel to serve older persons.[202]

Dr. Thomas Plaut, deputy director of the National Institute of Mental Health, told the Commission that there are still relatively few professionals and paraprofessionals in the mental health area with particular interest in training in relation to older persons. He also pointed out that NIMH was attempting to focus greater attention in general training of mental health professionals and paraprofessionals on the needs of older persons and was developing some demonstration projects in this area.[203]

Dr. Julius Richmond, Assistant Secretary for Health of the Department of Health, Education, and Welfare, in his written response to questions submitted by the Commission, also acknowledged that shortages of trained personnel for the aged exist, specifically in community mental health centers and in long-term care facilities. He noted that the psychiatric and psychological curriculum needs to be strengthened in the geriatric services area. He concluded by stating that "priority in the award of NIMH training grants will be given to those programs which address the priorities of services to special target populations (the aged and children being two)."[204]

A lack of mental health professionals trained to work with children has also been raised as a barrier to adequately serving children. As part of its 1971 evaluation of mental health services for children, the American Psychiatric Association surveyed all federally-assisted community mental health centers to determine the nature of their services to children and adolescents. Of the centers that responded, 44 percent indicated that the lack of staff with training and experience to work with children and adolescents was one of the most significant problems in providing services to these age groups.[205]

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[199] Dr. Butler Testimony, *Washington, D.C. Hearing*, pp. 12–13.

[200] Feldman Interview; Battjes Interview; Bartleson-Baxter Interview.

[201] Dr. Simon Testimony, *San Francisco Hearing*, pp. 160, 166–67.

[202] For example, see Mary Krane, president, Citizens Advisory Board, Northwest Denver Comprehsenive Community Mental Health Center, testimony, *Denver Hearing*, p. 11; Dr. Kauver Testimony, *Denver Hearing*, pp. 10–11 and Dr. Pfeiffer Testimony, *Denver Hearing*, pp. 20–21; Jeffrey Solomon, director, community services, Miami Jewish Home and Hospital for the Aged, testimony, *Miami Hearing*, p. 159.

[203] Dr. Plaut Testimony, *Washington, D.C. Hearing*, p. 238.

[204] Dr. Julius Richmond, letter to Dr. Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, Oct. 18, 1977.

Some of the participants in an NIMH-sponsored workshop held in May 1977 to develop recommendations on future directions for child mental health services also concluded that the shortage of professionals trained in child psychiatry, psychology, and social work hinder the delivery of services to children.[206]

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[205] *Mental Health Services for Children,* p. 80.

[206] Barbara J. Sowder, Ph.D., ed., "Community Mental Health Services for Children: Recent Experiences and Future Planning" (Summary of the Proceedings of a Workshop on Community Mental Health Services for Children, Washington, D.C., 1977).

Chapter 3

Legal Services

The legal services program is authorized by the Legal Services Corporation Act of 1974, as amended.[1] The act established the Legal Services Corporation[2] and authorized it to enter into grant or contractual arrangements with individuals, partnerships, firms, corporations, nonprofit organizations, and, upon certain conditions, with State and local governments to provide financial assistance to programs of legal assistance for eligible low-income persons.[3]

The Commission's review of the legal services program identified discrimination on the basis of age in two areas. First, insufficient outreach efforts were found to affect particularly the opportunities of older persons to participate in the program. Second, some legal services projects rely on funds provided under age-categorical programs, such as Title III of the Older Americans Act[4] or on other general population-based programs, to substitute for, rather than supplement, the use of Corporation funds to serve older persons.

Program Description

Federally-funded legal services projects were first established in 1966 under the former Office of Economic Opportunity (OEO).[5] For a short period of time, the legal services program was administered by the successor agency to OEO, the Community Services Administration.[6] In 1974 the Legal Services Corporation Act was enacted into law as title X of the Economic Opportunity Act of 1964 and transferred responsibility for administration of the legal services program to a new, independent, nonprofit corporation entitled the Legal Services Corporation.[7]

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[1] 42 U.S.C. §§2996-2996l (Supp. V 1975), as amended by Legal Services Corporation Act Amendments of 1977, Pub. L. No. 95-222, 91 Stat. 1619. The Commission's review of the legal services program took place prior to the 1977 Amendments to the Act; therefore, all citations unless otherwise indicated are to the 1974 Act.

[2] 42 U.S.C. §2996b(a) (Supp. V 1975).

[3] 42 U.S.C. §2996e (Supp. V 1975).

[4] 42 U.S.C. §3021 (Supp. V 1975).

[5] The enabling legislation was the Economic Opportunity Act of 1964, Pub. L. No. 88-452, 78 Stat. 508 [current version cited as Community Services Act of 1974, 42 U.S.C. §§2711-2995b (Supp. V 1975)], although there was no specific

The Corporation is run by an 11-member board of directors, appointed by the President with the advice and consent of the Senate.[8] The board chooses the president of the Corporation who also serves as a nonvoting, ex officio member of the board.[9]

One purpose of the Corporation is to provide financial support for legal assistance to persons financially unable to afford adequate legal counsel.[10] Such assistance is available at no cost and is limited to noncriminal proceedings or matters.[11]

The act authorizes the Corporation to make grants to, or contracts with, individuals, partnerships, firms, corporations, nonprofit organizations, and, upon certain conditions, with State and local governments to support legal services programs for eligible low-income persons.[12] Other Corporation functions include research, serving as an information clearinghouse, and providing training and technical assistance to local legal services programs.[13]

Legal services is a project grant program in that the Corporation awards funds in its discretion directly to applicants whose project proposals meet the requirements of the act and the regulations and other policies established by the Corporation. Each project must establish eligibility criteria for potential clients within guidelines established by the Corporation.[14] Preference in the provision of legal assistance is to be given to those least able to afford it.[15] Projects must establish maximum annual income levels

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statutory reference to legal services. The act was amended by the Economic Opportunity Amendments of 1966, Pub. L. No. 89-794, 80 Stat. 1451. Section 215 of the Amendments added §211-1(b) to the Economic Opportunity Act to provide specifically for a legal services program. The Economic Opportunity Act of 1967, Pub. L. No. 90-222, §104, 81 Stat. 672, repealed §211-1(b) and replaced it with §222(b)(3). The Legal Services Corporation Act, 42 U.S.C. §2996 (Supp. V 1975) repealed §222(b)(3).

[6] 42 U.S.C. 2941(d) (Supp. V 1975).

[7] 42 U.S.C. §2996 (Supp. V 1975).

[8] 42 U.S.C. §2996c(a) (Supp. V 1975).

[9] 42 U.S.C. §2996d(a) (Supp. V 1975).

[10] 42 U.S.C. §2996b (Supp. V 1975).

[11] 42 U.S.C. §2996f(b)(1) (Supp. V 1975).

[12] 42 U.S.C. §2996e(a)(1)(A) (Supp. V 1975).

[13] 42 U.S.C. §2996e(a)(3) (Supp. V 1975).

[14] 42 U.S.C. §2996f(a)(2)(A)-(B) (Supp. V 1975).

[15] 42 U.S.C. §2996f(a)(2)(C) (Supp. V 1975). The Legal Services Corporation Act Amendments of 1977 repealed this provision and provided instead that the Corporation shall insure that "(i) recipients [of Corporation funds] consistent with goals established by the Corporation, adopt procedures for determining and implementing priorities for the provision of such assistance taking into account the relative needs of eligible clients for such assistance (including such outreach, training, and support services as may be necessary), including particularly the needs for service on the part of significant segments of the population of eligible clients with special difficulties of access to legal services or special legal problems (including elderly and handicapped individuals); and (ii) appropriate training and support services are provided in order to provide such assistance to such significant segments of the population of eligible clients. . ." Legal Services Corporation Act Amendments of 1977, Pub. L. No. 95-222, §9(b), 91 Stat. 1621.

for persons to be eligible to receive legal services.[16] These levels may not exceed 125 percent of the official poverty line defined by the U.S. Office of Management and Budget.[17]

Currently, approximately 320 legal services projects are supported with Corporation funds.[18] Most of these are local projects that provide ongoing legal assistance directly to clients. Thirty-eight projects are demonstration efforts designed to test alternative methods of legal services delivery.[19] Thirteen projects are support centers intended to provide specialized "back-up" assistance for the regular legal services offices. These centers specialize either in a specific area of substantive law, for example, the National Consumer Law Center, or in the legal problems of a distinct client group, for example, the Migrant Legal Action Project.[20]

Eight of the demonstration projects have as one of their specific concerns the development of better methods for reaching and serving older persons, including judicare, contract and prepaid services, and the *pro bono* involvement of the private bar. The National Senior Citizens Law Center in Los Angeles, one of the support centers funded by the Corporation, focuses exclusively on the legal problems of older persons.[21] Three other programs funded by the Corporation also concentrate on the legal problems of this group—Legal Services for the Elderly Poor in New York City, the Council of Elders in Boston, and the Senior Citizens Project of the California Rural Legal Assistance program. Two support centers specialize in the legal problems of young persons—the Youth Law Center in San Francisco and the National Juvenile Law Center in St. Louis.[22]

Commission staff visited 14 legal services projects during the course of the field study and public hearings. Appendix B lists the projects that were visited.

Summary of the Record

Program Participants

National data on the poverty population serve as a gross indicator of the numbers of persons who are eligible for legal services. Data on persons eligible for the services of each legal services project are not readily attainable because each project must, within certain prescribed limits, set its own financial eligibility criteria.[23] Also, Bureau of the Census poverty data are not broken down for geographic units comparable to the service areas of the projects.

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[16] 41 Fed. Reg. 51,604, 51,606 (1976) (to be codified in 45 C.F.R. §1611.3(a)).

[17] 41 Fed. Reg. 51, 604, 51, 606 (1976) (to be codified in 45 C.F.R. §1611.3(b)).

[18] Thomas Ehrlich, president, Legal Services Corporation, testimony, *Hearing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Sept. 26–28, 1977, vol. I, p. 145 (hereafter cited as *Washington, D.C. Hearing*).

[19] Ehrlich Statement, *Washington, D.C. Hearing*, vol. II.

[20] Legal Services Corporation, *Budget Request for Fiscal Year 1978*, p. 50.

[21] Thomas Ehrlich, letter to Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, Dec. 20, 1977 (hereafter cited as Ehrlich letter).

[22] Ehrlich Statement, *Washington, D.C. Hearing*, vol. II.

[23] 41 Fed. Reg. 51,604, 51,606 (1976) (to be codified in 45 C.F.R. §1611.3).

The percentage of persons eligible for legal services who are older persons is estimated to be from 13.6 to 25 percent, as shown by a statement of the Legal Services Corporation:

> Based on the 1970 census, there were approximately 4.7 million persons over 65 with incomes below the poverty line, a figure that translates to 16.2 percent of the total poverty population. Recent figures suggest that the percentage of elderly poor has declined slightly. An April 1976 report to the Congress by the Department of Health, Education, and Welfare, for example, states that persons over 65 constitute 13.6 percent of the poverty population. Although some groups have suggested that the percentage of the elderly poor is more than 25 percent, that figure is based on the adult poverty population. Because legal services programs serve children and handle a substantial number of child-related problems, such as problems dealing with AFDC benefits and custody matters, those figures are not suitable for the Corporation's planning purposes.[24]

No one has suggested, however, that persons 65 or over have less need for legal services than the balance of the poverty population. A 1975 report of the Senate Committee on Labor and Public Welfare concerning extension of the Older Americans Act set forth both older persons' need for legal services and the benefit to be gained from their access to such services:

The hearings before the Subcommittee on Aging have underscored the need to expand the provision of legal services to the elderly. Perhaps more than any other group, the elderly rely upon complex public and private programs and institutions for their daily subsistence. Many have no experience at dealing with the governmental programs and large bureaucracies upon which they have become largely dependent.

Superimposed upon the lives of the elderly, is a vast array of complex statutory, regulatory, and decisional law. Their shelter may be provided or secured under Federal or State public or subsidized housing laws, relocation laws, and zoning laws. Their health is often dependent upon Medicare, Medicaid, laws regulating nursing homes, and laws relating to prescription drugs. Their nutrition is often secured by the Title VII Nutrition program, the Food Stamp program, and other Federally established nutrition programs. The source of their incomes may be Social Security, Supplemental Security Income under Title XVI of the Social Security Act, other Federal retirement benefit programs, or private pensions. Finally, the dignity of their personal freedom and control of their personal and real property is subject to the complex laws of guardianship, conservatorship, and involuntary commitment. They must have someplace to turn for adequate and effective legal assistance in dealing with a vast complex of crucial legal issues if they are to take full advantage of the Governmental programs designed to benefit the elderly.[25]

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[24] Thomas Ehrlich, letter to Rep. Robert Kastenmeier, Mar. 9, 1972, in U.S., Congress, House, Committee on the Judiciary, Subcommittee on Courts, Civil Liberties, and the Administration of Justice, *Legal Services Corporation Act: Hearings on H.R. 3719*, 95th Cong., 1st sess., 1977, pp. 353–54 (hereafter cited as *Hearings on H.R. 3719*). The Department of Health, Education, and Welfare report cited is the *Measure of Poverty* which was required by the Education Amendments of 1974.

Older persons' need for legal services was also addressed at the San Francisco hearing by Hiram Smith, director of the San Francisco Neighborhood Legal Assistance Foundation: "We have banded together in an attempt to find ways and means to increasing the availability of legal services to the elderly in San Francisco because there is an appalling need for these services."[26]

The Commission is unaware of any assessment of the legal needs of persons under age 19. Although extent of need may not have been gauged, testimony at the San Francisco hearing indicated areas in which younger persons require legal representation—education, institutionalization, custody, foster care, and adoption.[27]

National caseload statistics for the legal services program have not been compiled since 1969.[28] The Commission obtained participant data for 82 local legal services projects for calendar year 1976. The data are useful although their utility is tempered by a variety of factors.[29] Table 3.1 summarizes the available data with regard to clients aged 65 or over.

A comparison of the service data with the census figures offered by the Legal Services Corporation indicates that substantial underservice to persons 65 or over exists. This age group represents 13.6 percent or more of the clients in only 6 of the 82 projects.[30] In 43 projects, persons

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[25] U.S., Congress, Senate, Committee on Labor and Public Welfare, *Older Americans Amendments of 1975*, 94th Cong., 1st sess., 1975, S. Rept. 255, pp. 24–25.

[26] Hiram Smith, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27–28, 1977, vol. I, p. 214 (hereafter cited as *San Francisco Hearing*).

[27] Stefan Rosenzweig, staff attorney, Youth Law Center, testimony, *San Francisco Hearing*, pp. 201–02.

[28] The legal services program has experienced problems throughout its history in the area of data collection. The Office of Economic Opportunity (OEO) had put into place a management information system. According to staff of the Legal Services Corporation, two studies of the legal services program found that "[t]he Management Information System (MIS) was poorly designed. . .[m] any grantees did not adhere to the MIS reporting requirements, so that MIS statistical reports were inaccurate and incomplete. OEO made little use of the reports it received." Alice Daniel, general counsel, Legal Services Corporation, memorandum to Thomas Ehrlich, Nov. 2, 1976. The Corporation has been developing a reporting system which it expects to implement in 1979. Ehrlich Testimony, *Washington, D.C. Hearing*, p. 146.

[29] The number of clients reported by a project may not include those to whom only advice was given. Law reform and community education efforts of local legal services projects may benefit many persons not recorded as clients.

A project may or may not include clients referred to a special component for older persons established under the auspices of the project with non-Corporation funds. If referred clients are not included and the project contributes substantial Corporation funds to the component, then data will be an underestimate of services. On the other hand, if referred clients are counted and the project contributes few or no Corporation funds, then data will represent an overestimate of service.

The Commission also recognizes that client data may not reflect other efforts undertaken by the Corporation itself to improve the quality and quantity of legal services for specific age groups, including funding support centers and demonstration projects and carrying out training and research efforts. See Ehrlich Letter.

[30] U.S., Commission on Civil Rights, Staff Report.

Table 3.1
Distribution of 82 Legal Services Projects by the Percent Participation of Persons 65+
Calendar Year 1976

Percent of Clients 65 or older	Number of Projects
All Projects	82
1 - 2.5	5
3 - 4.5	15
5 - 6.5	23
7 - 8.5	18
9 -10.5	10
11+	11

Source: U.S. Commission on Civil Rights, Staff Report on Legal Services.

65 or over represent less than one-half of 13.6 percent.

Other sources have also indicated the existence of underservice to older persons in the legal services program. Thomas Ehrlich, president of the Legal Services Corporation, told the Senate Special Committee on Aging in 1976:

> Although there has been no systematic analysis of the caseloads of all legal services programs funded by the Corporation, we have estimates of caseload statistics from some programs. At the request of this committee, we recently received estimates of the number of elderly clients served from nine programs operating in the States of Nebraska, Iowa, and South Dakota. The estimates of clients over 65 ranged between 5 percent and 20 percent. In most of those programs, the percentage of elderly clients was less than the percentage of the eligible population that is elderly.[31]

Legal Research and Services for the Elderly (LRSE), an arm of the National Council of Senior Citizens, collected caseload statistics for a 6-month period covering late 1976 and early 1977 for legal services projects that were operating in the Federal regions in Boston, Philadelphia, and Atlanta. Except for two projects, the estimates obtained showed wide disparities between the percent of eligible persons who are 65 or over and the percent of persons served in that age group.[32] David Marlin, director of LRSE, testified:

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[31] U.S., Congress, Senate, Special Committee on Aging, *Hearing on Improving Legal Representation for Older Americans*, 94th Cong., 2d sess., 1976, pt. 4, Thomas Ehrlich, testimony, p. 262 (hereafter cited as *Hearing on Improving Legal Representation*).

> Assuming that these. . .programs are fairly representative of Legal Services Corporation funded projects, these figures demonstrate that the elderly poor are generally underrepresented by legal services programs.[33]

During the Commission's field study and public hearings, the directors of two projects indicated that special components to serve older persons had been instituted because these persons were not being served adequately.[34] When Commission staff visited the projects, these components were financed primarily from sources other than Corporation funds.

The issue of legal services to young persons also arose during the course of the study. Most projects for which the Commission had age data, tabulate such data using the categories 6–15 and 16–21, or under 21, or under 22, instead of 6–15 and 16–21. It was thus not possible to determine how many persons under age 19 were served. Fifty-seven projects for which data were available use the categories 6–15 and 16–21. Most of these projects report clients 6–15 as a relatively small percent of all clients served.[35]

Stefan Rosenzweig, a staff attorney with the Youth Law Center in San Francisco, indicated that problems in service to young persons exist:

> I think there's been really a very serious underrepresentation of young people in legal services programs. I, myself, worked for the Legal Aid Society of Alameda County for about 7 years, and also worked for the Center for Law and Education, which does backup in the area of educational law for legal services programs.
>
> As a legal services attorney you rarely see a young person come into your office. I know in my own experience over a number of years in neighborhood work, I only saw a couple of kids and usually they involved school suspension cases.
>
> Occasionally a young person will come in concerned about an emancipation, but unlike the old, there are very, very few programs that specialize in young people law. There are a number of very, very serious lacks of representation in legal services programs.[36]

Several reasons were offered to explain the small number of young persons served. Parents may represent the interests of their children and the parents will be reported as the clients. Children and their parents, however, may have adverse interests. Peter Siegel, Executive Director of Legal Services of Greater Miami, explained why children may not be represented in such cases:

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[32] *Hearings on H.R. 3719,* David Marlin, testimony, pp. 181–3. Mr. Marlin acknowledged that not all legal services projects funded in the regions were included, but only those from whom caseload statistics had been obtained. He added that the statistics reported are estimates submitted by the local projects themselves, p. 183.

[33] Ibid., p. 183.

[34] Greg Dallaire, director, Evergreen Legal Services, interview in Seattle, Wash., May 4-5, 1977 (hereafter cited as Dallaire Interview); Edward Beis, director, Cook County Legal Assistance Foundation, interview in Chicago, Ill., May 24, 1977 (hereafter cited as Beis Interview).

[35] U.S., Commission on Civil Rights, Staff Report.

[36] Rosenzweig Testimony, *San Francisco Hearing,* p. 201.

> [W]here children are involved—custody termination proceedings, abandonment proceedings, and the like—because of the mechanics of the way that counsel are obtained, we tend to end up representing the parents, rather than the children. Whether there is a divergence of interest—well, there is from time to time. Since the courts have not yet come around to the notion that children have a right to counsel when caught up in the process, other than when it is more or less of a criminal nature, the people we get in our office are the parents.
>
> That reflects in our statistics, and it reflects, in actuality, in the representation. . .once we have. . .the parents in the office—because of the conflict of interest rules—we cannot very well be representing the children.[37]

LeRoy Cordova, Director of Colorado Rural Legal Services, attributed underrepresentation of young persons in part to the statutory restrictions on providing legal assistance to juveniles.[38] The President of the Legal Services Corporation told the Commission, however, that the statutory restriction on representing juveniles

> does not appear to have had any substantial adverse affect on the number of juvenile cases handled by the legal services programs, but its complexity may have created confusion in some local offices and may have discouraged them in particular cases from undertaking representation of juveniles.[39]

Outreach Activities

The absence of an ongoing and systematic outreach program was identified as a major cause for underservice to older persons. The importance of outreach as a means of reaching older persons has been underscored by many people working in the fields of legal services and aging.

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[37] Peter Siegal, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida*, Aug. 22–23, 1977, vol. I, p. 168 (hereafter cited as *Miami Hearing*).

[38] LeRoy Cordova, testimony, *Hearing Before the United States Commission on Civil Rights, Denver, Colorado*, July 28–29, 1977, vol. I, p. 140 (hereafter cited as *Denver Hearing*). The 1974 act provided that

> No funds made available by the Corporation. . .may be used. . .(4) to provide legal assistance. . .to any unemancipated person of less than eighteen years of age, except (A) with the written request of one of such person's parents or guardians, (B) upon the request of a court of competent jurisdiction, (C) in child abuse cases, custody proceedings, persons in need of supervision (PINS) proceedings, or cases involving the initiation, continuation, or conditions of institutionalization, or (D) where necessary for the protection of such persons for the purpose of securing, or preventing the loss of benefits, or securing or preventing the loss or imposition of, services under law in cases not involving the child's parent or guardian as a defendent or respondent. 42 U.S.C. §2996f(b)(4) (Supp. V. 1975).

The restrictions on representation of juveniles were repealed by the Legal Services Corporation Act Amendments of 1977, Pub. L. No. 95–222, §10, 91 Stat. 1619.

[39] Ehrlich Statement, *Washington, D.C. Hearing*, vol. II.

When Corporation President Ehrlich informed the Senate Special Committee on Aging that, based on estimates obtained from nine legal services programs operating in Nebraska, Iowa, and South Dakota, the percentage of older clients in most of the programs was less than the percentage of the older eligible population, he also suggested an explanation for the disparities:

> The program directors believe that this is due mainly to the transportation difficulties that poor elderly people have, especially in rural areas. In addition, they stated that some elderly persons are less aware of the fact that legal services are available to them and do not understand how the programs can be helpful. The programs in those states that served a relatively high proportion of elderly clients were ones that are able to and do engage in aggressive outreach efforts, such as making presentations in senior citizens centers and nursing homes.[40]

Mr. Ehrlich told the Commission that their relative lack of mobility creates special problems in providing legal services to older persons and to juveniles:

> These [outreach] activities are essential to increasing services to the elderly and juveniles. In the next several years considerable energy will also be directed toward assisting rural programs to develop the best possible means of overcoming the barriers of distance and lack of transportation that adversely affect all of the rural poor, but especially the elderly and juveniles.[41]

A. C. Wharton, of the Memphis and Shelby County Legal Services program in Tennessee, drawing on the experiences of his program, reaffirmed the importance of outreach in serving older persons. He indicated that without special outreach efforts many legal problems confronted by older persons in his area would have continued unresolved. He said that 59 percent of the older persons served by that program had been assisted at locations other than the central office. During a 6-month period, legal services attorneys served approximately 60 percent of the older clients in their own homes. Mr. Wharton indicated that this procedure was instituted because many of the older persons had a handicap or had problems obtaining transportion that limited their mobility and thus their access to legal assistance.[42]

David Marlin, director of Legal Research and Services for the Elderly, in describing his report on client information obtained for 28 legal services projects, explained that the 2 programs reporting high percentages of older clients had special units "to do outreach and focus on the needs of the elderly poor."[43]

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[40] *Hearing on Improving Legal Representation*, Thomas Ehrlich, testimony, p. 262.

[41] Ehrlich Statement, *Washington, D.C. Hearing*, vol. II. Mr. Ehrlich has also pointed out to the Commission that other population groups have problems in obtaining access to legal services similar to those of older persons and juveniles, including migrants, persons with limited English-speaking ability, the physically handicapped, and Native Americans. Ehrlich Letter.

[42] *Hearing on Improving Legal Representation*, A. C. Wharton, testimony, pp. 266–67.

Information obtained through the Commission's field study and public hearings supports the contention that the lack of adequate and appropriate outreach efforts—outreach which takes into account problems of mobility, lack of information on the availability of the programs, the failure to recognize problems as "legal," and perception of the service as charity—operates as a barrier, particularly to older persons' obtaining legal services. LeRoy Cordova described the situation to the Commission in the following way:

> I think that it can be said it is difficult to serve the senior population in a metropolitan area. It is, I would maintain, even more difficult to serve the senior population in rural Colorado where mobility or lack of mobility of that age group is even more detrimental because they aren't receiving any kind of services including legal services. We have not had the staff or the resources to outreach in most of our areas other than some very occasional contacts with senior citizen centers, so I think that our lack of a staff and resources on outreach combined with a lower mobility in the age group, especially that 60 and over, combines to make our services probably less available to the older age group than they would be.[44]

Despite the recognized need for efforts to reach persons in underserved age groups, only two of the seven projects visited during the field study had regular planned outreach programs.[45] In one of these, outreach efforts were carried out by a special component for older persons funded largely with non-Corporation funds.[46]

All projects were taking some, though unsystematic and often sporadic, measures to inform or educate eligible persons about the availability and use of legal services and to ameliorate some of their transportation problems.[47] Five projects used referral organizations, five used pamphlets, three used posters, and four utilized newspapers to provide information.[48] Three projects distributed manuals on substantive issues and six visited or otherwise worked with community groups.[49] Each visited shut-in clients in their homes.[50] Some projects had developed innovative methods of reaching the eligible population. Two provided training to social service agency staffs to identify legal problems.[51] One project had "outpost offices," another "circuit-rode" to social services agencies, and a third allowed interviews over the telephone.[52]

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[43] *Hearings on H.R. 3719*, Marlin Testimony, p. 183.

[44] Cordova Testimony, *Denver Hearing*, p. 142.

[45] David Lander, director, Legal Aid Society of the City and County of St. Louis, interview in St. Louis, Mo., Apr. 4, 1977 (hereafter cited as Lander Interview); and Dallaire Interview.

[46] Paul Agid, director, Elderly Project, Evergreen Legal Services, interview in Seattle, Wash., May 4, 1977 (hereafter cited as Agid Interview).

[47] Lander Interview; Dallaire Interview; Agid Interview; Leo Delicata, acting director, Pine Tree Legal Assistance Foundation, interview in Portland, Me., May 18, 1977 (hereafter cited as Delicata Interview); Barry Powell, director, Central Mississippi Legal Services, interview in Jackson, Miss., Apr. 26, 1977 (hereafter cited as Powell Interview); Edward Beis, director, Cook County Legal Assistance Foundation, interview in Chicago, Ill., May 24, 1977 (hereafter cited as Beis Interview); Frank Christian, director, Bexar County Legal Aid Association, interview in San Antonio, Texas, Apr. 29, 1977 (hereafter cited as Christian Interview); Sheldon Roodman, executive director, Legal Assistance Foundation of Chicago, interview in Chicago, Ill., May 23, 1977 (hereafter cited as Roodman Interview); Joel Stein, Supervising Attorney, Uptown Neighborhood Office, Legal Assistance Foundation, interview in Chicago, Ill., May 23, 1977 (hereafter cited as Stein Interview); and Joel Seidman, Supervisory Attorney, Evanston Office, Cook County Legal Assistance Foundation, interview in Evanston, Ill., May 24, 1977 (hereafter cited as Seidman Interview).

If these outreach efforts are representative of the efforts undertaken by all legal services projects, three reasons explain why such efforts have not solved the problem of underservice to persons 65 or older.

First, the outreach efforts, though varied, were only extensive in the two projects with formal outreach programs. For example, one project director stated that staff were sent to visit shut-ins only 1 day a month.[53] Another director disliked sending staff out for this purpose.[54] One project paid for transportation, if necessary, but did not advertise this service.[55] Staff of one project visited nursing homes for 5 months but said that they discontinued the practice when requests for assistance began coming from previously served clients.[56] One director did not consider speaking to community groups to be a good use of time.[57] Another director would not seek out groups to address but would respond only upon request.[58] One project visited social service agencies, but only 1 day a month.[59]

Second, the use of mass media was limited, although when employed, it proved very effective. A senior citizens component of one project conducted a formal outreach campaign using a wide variety of means. The campaign was so successful that outreach efforts had to be severely curtailed. Eighty-five percent of the increase in clients was due to one technique—public service television announcements.[60] Another project director appeared on a television talk show; the project received 150 calls the next day from persons requesting service.[61] A third project stopped public service announcements on radio because too many people were responding.[62]

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[48] Referral Organizations: Delicata Interview; Beis Interview; Lander Interview; Roodman Interview; and Agid Interview. Pamphlets: Christian Interview; Delicata Interview; Beis Interview; Lander Interview; and Agid Interview. Posters: Lander Interview; Christian Interview; Agid Interview. Newspapers: Beis Interview; Lander Interview; Roodman Interview; and Agid Interview.

[49] Manuals: Delicata Interview; Roodman Interview; and Kathy O'Blennis, staff attorney, Elderly Unit, Legal Aid Society of the City and County of St. Louis, interview in St. Louis, Mo., Apr. 4, 1977 (hereafter cited as O'Blennis Interview). Community Groups: Lander Interview; Delicata Interview; Dallaire Interview; Agid Interview; Christian Interview; Roodman Interview; Beis Interview.

[50] Delicata Interview; Christian Interview; Powell Interview; Stein Interview; O'Blennis Interview; Seidman Interview; Agid Interview.

[51] O'Blennis Interview; Beis Interview; Seidman Interview.

[52] Outpost offices: Beis Interview. Circuit Riding: Delicata Interview. Telephone Interview: Beis Interview.

[53] Seidman Interview.

[54] Powell Interview.

[55] Elizabeth Levine, director, Clayton Neighborhood Office, Legal Aid Society of the City and County of St. Louis, interview in St. Louis, Mo., Apr. 4, 1977.

[56] Seidman Interview.

[57] Roodman Interview.

[58] Christian Interview.

[59] Delicata Interview.

[60] Agid Interview.

Third, except for senior citizen components, few efforts to inform and educate eligible persons were targeted to older persons or other underserved age groups. The nursing home effort was mentioned above. Two project directors mentioned that schools had been visited,[63] and one director mentioned contact with nutrition sites funded under Title VII of the Older Americans Act (which serve, primarily, persons aged 60 or over).[64] One project hired a social worker, whose duties included working with social service agencies that served older persons, children, and youth.[65]

Few individuals with whom Commission staff spoke doubted the efficacy of outreach. Jon Nicholls, director of Metropolitan Denver Legal Services, attributed a rise in clients aged 60 or over from 6 percent to 14 percent of the caseload in his program to an "increased sensitivity on our part to the needs of older adults and the effort. . .to put together an outreach efforts for these clients."[66] Some directors of legal services projects, when asked why they had no formal outreach programs, responded that limited resources prevented such efforts. They said that expanding resources for outreach would mean cutting back on direct services, and a project could not handle all the clients who would apply if outreach efforts were successful. Hiram Smith, director of the San Francisco Neighborhood Legal Assistance Foundation, testified, "The problem is. . .when you take care of those who come through the door you've pretty much used yourself up."[67]

Lack of outreach was in some instances a means to control the number of persons applying for service. Two project directors maintained that they did not have more applicants then they could serve, but conceded that the projects were not meeting all of the needs of the eligible population.[68]

Joaquin Celaya, with the Legal Services Corporation in San Francisco, testified:

> The area of outreach is an area that we're particularly concerned with. It's fair to say that there's been a lack of outreach. . .
>
> Then, when you do outreach. . .the work has just begun, because the product of that outreach. . .is that. . .more people will be aware of what legal service can do for them, and you have additional people needing services aware of what these rights are.[69]

Corporation President Ehrlich corroborated the justifications offered by program administrators for not taking outreach efforts:

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[61] Roodman Interview.

[62] Powell Interview.

[63] Delicata Interview; Christian Interview.

[64] Christian Interview.

[65] Ibid.

[66] Nicholls Testimony, *Denver Hearing*, p. 141.

[67] Smith Testimony, *San Francisco Hearing*, p. 217.

[68] Beis Interview; Christian Interview.

[69] Joaquin Celaya, testimony, *San Francisco Hearing*, p. 211.

> When legal services offices are already besieged with many more requests for service than they can meet, their failure to expand the time and money necessary to reach out to other parts of the community is an understandable response to totally inadequate funding conditions.[70]

He added that with rising budgets for existing legal services projects and the establishment of new projects, he expected that "substantial outreach efforts into all segments of the poverty community will be made."[71] During the field study, however, Commission staff learned that expanding or instituting outreach efforts would apparently have a low priority in the event of increased funds.

One project director asserted that if his program received increased funds, he would increase staff salaries, raise the financial eligibility criteria, and expand services to presently unserved rural areas.[72] A second director stated that any budget rise would be "eaten up" by salary increases.[73] In addition, there was pressure from the city administration to raise the eligibility level.[74]

The necessity for outreach to reach older persons, even without increasing budgets, was underscored by Edward King, directing attorney of the Washington office of the National Senior Citizens Law Center:

> I believe very strongly that emphasis [in reference to older persons] needs to be increased in the area of outreach or there will be this continuing disparity until we have a perfect situation where all programs have the funds they are entitled to, or that they need to do an absolutely comprehensive job.[75]

All outreach activities will require some expenditure of funds; some efforts, however, can be made without a substantial commitment of resources. Arturo Lucero, deputy director of the Legal Services Corporation office in Denver, acknowledged this and the problem of insufficient outreach to older persons by quoting from a letter from the president of the Legal Services Corporation to all program directors. The letter announced the signing of a statement of understanding between the Administration on Aging of the Department of Health, Education, and Welfare, and the Corporation:

> . . .With limited resources legal services programs are able to provide only limited access for all of the poor, including the elderly. As more funds became available, however, it is essential that all of us become sensitive to these special problems associated with delivering services to the elderly. We know that older persons with legal problems do not always find their way to some legal services

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[70] Ehrlich Statement, *Washington, D.C. Hearing*, vol. II.

[71] Ibid.

[72] Christian Interview.

[73] Dallaire Interview.

[74] Agid Interview.

[75] Edward King, testimony, *Washington, D.C. Hearing*, p. 159.

> offices and many of them may not even recognize that they have legal problems for which they can obtain help. . . .Where programs are not reaching the elderly poor, and where these special efforts (outreach, specialized staffing, etc.) are not already underway, aggressive steps should be taken.

> The statement of understanding emphasizes certain activities that can occur now without substantial additional resources, including outreach and community education in senior citizen centers, nutrition sites, elderly housing projects, nursing homes, and other places where elderly poor live and congregate.[76]

Other efforts can be made. Public service announcements on radio and television have been shown to be effective. Greater coordination with social service agencies may increase the number of older and younger clients. Such coordination should include taking advantage of the outreach, education, and transportation resources of the network of State and area agencies on aging established under the Older Americans Act, as suggested in the statement of understanding between the Corporation and the Administration on Aging.[77] Training social service personnel to recognize legal problems of older persons may effect an increase in referrals. Finally, projects can seek outside funding to support outreach activities. One legal services project received a Comprehensive Employment and Training Act grant to operate a "hotline" and a United Way grant to train outreach workers.[78]

Limited resources prevent any group from receiving adequate legal services. Under present funding levels all eligible persons cannot be served. But if outreach efforts are not made, certain age groups will continue to bear a disproportionate burden of limited resources. As stated by Edward King:

> . . .the absence of adequate funds to perform all the services that are immediately demanded of programs at the present time falls more heavily upon the aged than any other group because of their special problems of mobility. . .and the aged, by and large, do not recognize their rights are being violated and tend to trust the kinds of institutions that have such great force upon their lives at that stage.[79]

Since all eligible persons cannot presently be served, outreach efforts are inexorably tied to the need to set priorities. One problem uncovered in the field study is that some projects base service priorities primarily on staff input; staff perceptions are in turn based on problems exhibited by walk-in clients. One project director said that "priorities have been pretty much based on the need that we've perceived in the number of complaints, of consultations and referrals for service that come from clients."[80] Use of this method may mean that the needs of those clients who do not walk in unsolicited are not assessed, and several administrators said that it is recognized that older persons will not simply "walk through the door."[81]

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[76] Arturo Lucero, testimony, *Denver Hearing*, pp. 144–45 (quoting from Thomas Ehrlich, letter to all project directors).

[77] Statement of Understanding between the Administration on Aging of the Department of Health, Education, and Welfare and the Legal Services Corporation, p. 2.

[78] Lander Interview.

[79] King Testimony, *Washington, D.C. Hearing*, p. 159.

Reliance on Alternative Funding Sources

Various other Federal programs serve as a source of funds for legal services. Such sources include Title III of the Older Americans Act,[82] Title XX of the Social Security Act,[83] general revenue sharing,[84] and community development block grants.[85] Of the 14 projects visited by the Commission during field work and the public hearings, 6 were receiving funds through one or more of these Federal programs.[86] In each case, the project had used all or part of the funds to set up a component to serve older persons.

In one project, all clients aged 60 or over were referred to the "senior citizens" component, which received negligible Corporation resources.[87] Resources made available to the lawyers providing services to older persons consisted primarily of use of the library, furniture, copying machine, and the services of the project's receptionist.[88] The effect of the special grant may have been that fewer older persons were served with Corporation funds. In a second case, the project director apparently believed that receipt of the special grant lessened the project's responsibility to increase the number of older persons served with Corporation funds.[89]

Even when a special grant has the effect of increasing the proportion of Corporation resources spent on older people, there is an issue of the magnitude of increase. One project that Commission staff visited contributed approximately 8 percent of its Corporation funds to its special component for older persons that was funded primarily from another source. According to the director of the older persons' unit, it was the policy of the legal services project to refer all older clients to this component.[90] Perhaps the 8 percent contribution represents a greater proportion of Corporation funds for older persons than was expended before the advent of the special outside grant, but it still represents a minimal amount.

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[80] Smith Testimony, *San Francisco Hearing*, p. 200.

[81] Robert Johnson, deputy regional director, Legal Services Corporation, interview in Chicago, Ill., May 25, 1977; Rita Geier, regional office, Legal Services Corporation, interview in Seattle, Wash., May 5, 1977; Nicholls Testimony, *Denver Hearing*, p. 141; Cordova Testimony, *Denver Hearing*, p. 142; Smith Testimony, *San Francisco Hearing*, pp. 216–17. This problem has been addressed to some extent by the Legal Services Corporation Amendments of 1977, Section 9(b), cited above.

[82] 42 U.S.C. §§3021–3029 (Supp. V 1975).

[83] 42 U.S.C. §§1397–1397f (Supp. V 1975).

[84] 31 U.S.C. §1221–1228, 1241–1243, 1261–1264 (Supp. V 1975).

[85] 42 U.S.C. §§5301–5317 (Supp. V 1975).

[86] Lander Interview; Dallaire Interview; Beis Interview; Ann Crisp, directing attorney, Senior Advocates of San Mateo County, Testimony, *San Francisco Hearing*, p. 207; Nicholls Testimony, *Denver Hearing*, pp. 139–40; Siegal Testimony, *Miami Hearing*, p. 166.

[87] Jean Ann Crisp, directing attorney, Senior Advocates of San Mateo County, and Peter Reid, director, Legal Aid Society of San Mateo County, interview in Redwood City, Calif., June 5, 1977.

[88] Crisp Testimony, *San Francisco Hearing*, p. 213.

[89] Beis Interview.

[90] Agid Interview.

Each of these cases indicates a reliance on an alternative funding source to solve a problem of underservice to older persons in a Corporation-funded project. Special grants served less to stimulate the expenditure of Corporation funds than to substitute for them.

Only two projects were using their special grants with the intent of increasing the number of older persons served with Corporation funds.[91] The director of one such project, Jon Nicholls of the Legal Aid Society of Metropolitan Denver, when asked whether all clients over age 60 were referred to the senior citizens law center, replied:

> No, they are not. At one time in the project's history there was an attempt to do that, but we found ourselves without sufficient funds to man a project which could serve all of those particular needs, so the history of our project has been one of less and less direct service and more and more attempts to get the ordinary channels of legal services opened up to this particular clientele.[92]

Two problems result from the kind of situations identified: (1) legal services projects may reduce or fail to increase their commitment of Corporation support to the legal problems of older persons; and (2) except for Title III of the Older Americans Act, and unless the action can be justified as affirmative action, using general population-based funds exclusively for one age group creates an anomalous situation insofar as other age groups are concerned.

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[91] Lander Interview; Nicholls Testimony, *Denver Hearing*, p. 141.

[92] Nicholls Testimony, *Denver Hearing*, pp. 141–42.

Chapter 4

Comprehensive Employment and Training Act Programs

The Comprehensive Employment and Training Act was enacted into law in December 1973.[1] The purpose of the act is to establish a decentralized system of Federal, State, and local programs to provide job training and employment opportunities for economically disadvantaged, unemployed, and underemployed persons while assuring that such services lead to maximum employment opportunities and enhance self-sufficiency.[2]

The Commission's review of the training and public service employment programs authorized under Titles I, II, and VI of the act revealed discrimination on the basis of age in several areas. Program administrators often narrowly interpret the goals of the programs: they consider their training programs to be for youth and their public service employment programs to be for persons they believe are in the "employable" age range—22 to 44. In addition, agencies administering the programs limit participation of some age groups so their program will be considered successful when measured against the Department of Labor's performance standards. Persons who are difficult to place in the private or public employment markets because of age discrimination in employment or mandatory retirement policies are screened out of the programs, as are persons who are not considered "cost effective" to train or employ. Low participation by certain age groups also appears to result from limited outreach, the use of contractors that had operated previous manpower programs and continue to serve the same age gruops, and, in some cases, the use of agencies to provide training that place age limitations on participation in their programs or on certain types of training within their programs.

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[1] Comprehensive Employment and Training Act of 1973, Pub. L. No. 93–203, 87 Stat. 839 [codified at 29 U.S.C. §§801-992 (Supp. V 1975) (amended 1974, 1976, and 1977)].

[2] 29 U.S.C. §801 (Supp. V 1975).

Finally, many of those administering the training and public service employment programs cite the existence of an age categorical program for older workers to justify limiting the participation of such persons in training or jobs provided under the Comprehensive Employment and Training Act.

Program Description

The Comprehensive Employment and Training Act (CETA) was enacted into law in December 1973.[3] When the Commission initiated its review of programs under the act, five of its then seven titles[4] authorized the provision of funds to States and units of local general government, among others, to establish training, public service employment, and other manpower services program and activities.[5]

Title I of the act, Comprehensive Manpower Services, makes funds available for the provision of training, education, and other services to enable economically disadvantaged persons to secure and retain employment at their maximum capacity.[6] Title II, Public Employment Programs, makes funds available to provide unemployed and underemployed persons with transitional employment in jobs providing needed public services in areas qualifying for assistance and, where feasible, related training and manpower services, with the objective of moving such persons into training or employment not financed under CETA.[7] Title III, Special Federal Responsibilities, authorizes funds to support, among other things, additional manpower services to special target groups including youth, persons of limited English-speaking ability, older workers, offenders, and manpower programs for Indians, migrants, and seasonal farmworkers.[8]

Title IV, the Job Corps, authorizes the establishment of residential and nonresidential centers to enable low-income, disadvantaged young persons to participate in intensive programs of education, vocational training, work experience, counseling, and other activities.[9] Title VI, Emergency Job Programs, authorizes funds for transitional public service employment, training, and related manpower services for unemployed and underemployed persons so they can obtain jobs not supported by CETA.[10]

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[3] In August 1977, the act was amended by the Youth Employment and Demonstration Projects Act of 1977, Pub. L. No. 95-93, 91 Stat. 627 (1977) which, among other things, added a new Title VIII to the act entitled the "Young Adult Conservation Corps."

[4] Comprehensive Employment and Training Act of 1973, Pub. L. No. 93-203, 87 Stat. 389 [codified at 29 U.S.C. §§801-992 (Supp. V 1975) (amended 1974, 1976, and 1977)].

[5] 29 U.S.C. §§801-992 (Supp. V 1975).

[6] 29 U.S.C. §§881-822 (Supp. V 1975).

[7] 29 U.S.C. §§841-851 (Supp. V 1975).

[8] 29 U.S.C. §§871-885 (Supp. V 1975). The Youth Employment and Demonstration Projects Act of 1977, Pub. L. No. 95-93, §201, 91 Stat. 627 (1977) amended Title III of the Comprehensive Employment and Training Act by providing for a new "Youth Employment Demonstration Programs."

The Commission's age discrimination study confined its review of CETA programs to those authorized under Title I, Title II, and Title VI.[11] Whereas Title I uses the term "prime sponsor," Titles II and VI employ the term "eligible applicant" to denominate those who are principally eligible to receive Federal grants. To facilitate reading, "prime sponsor" will be used throughout this chapter, despite the fact that it is not used in the law interchangeably with "eligible applicant."

Funds provided under Title I may be used to support a wide range of employment and training services, including the following: outreach to make persons aware of the availability of the services and persuade them to use the services; orientation, counseling, education, and institutional skill training to prepare the individual for entry into the labor market or to qualify for more productive job opportunities; on-the-job training; payments to public or private employers to induce them to expand job opportunities; payments to persons to enable them to support themselves in training; and other services such as health care or child day care to enable individuals to take advantage of employment opportunities.[12] Title I funds may also support transitional public service employment programs, but relatively little funding has been used in this way. Funds have been concentrated on training.[13]

Financial assistance under Title I is available to "prime sponsors," which means: States, units of general local government having a population of 100,000 or more, any consortia of units of general local government that include a unit with a population of 100,000 or more, any unit or combination of units of general local government that have been determined by the Secretary of Labor to serve a substantial portion of an area with a high level of unemployment and to be capable of carrying out the programs as effectively as the State, or a limited number of existing concentrated employment program grantees that meet certain specified conditions.[14] A State may qualify as a prime sponsor for an area within the jurisdiction of a non-State, eligible prime sponsor only when that eligible prime sponsor has not submitted an approvable comprehensive manpower plan for its area,[15] or has its plan terminated in whole or in part by the Secretary,[16] or consents to be served by the State.[17] State prime sponsors are commonly referred to as "balance-of-State" prime sponsors, meaning that they are responsible for that area within the State's jurisdiction that is not covered by a plan of another prime sponsor.[18]

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[9] 29 U.S.C. §§911-929 (Supp. V 1975).

[10] 29 U.S.C. §§961-966 (Supp. V 1975) and 29 U.S.C.A. §§961-969 (West Supp. 1977). Title VI had been added to the Comprehensive Employment and Training Act by the Emergency Jobs and Unemployment Assistance Act of 1974, Pub. L. No. 93-567, 88 Stat. 1845 [codified in §§961-966 and scattered sections of 29 U.S.C. (Supp. V 1975)]. Title VI was reauthorized and amended in October 1976 by the Emergency Jobs Programs Extension Act of 1976, Pub. L. No. 94-444, 90 Stat. 1476 [codified in scattered sections of 29 U.S.C.A. (West Supp. 1977)].

[11] The Commission reviewed the programs authorized under these titles in light of the statutory, regulatory, and administrative requirements in force from July 26, 1976, through July 1977. Since that time the act has been amended twice and the regulations, numerous times. (The most up-to-date compilation of the Federal regulations can be found at 42 Fed. Reg. 55, 726-83 (1977)). As a result, some program requirements have changed. Any significant changes relevant to the study are indicated in footnotes.

[12] 29 U.S.C. §811 (Supp. V 1975).

[13] U.S., Department of Labor, and Department of Health, Education, and Welfare, *Employment and Training Report of the President* (1977), pp., 45-46 (hereafter cited as *Employment and Training Report, 1977*).

The Department of Labor's Regional Administrator determines whether a prime sponsor applicant is eligible to be designated as a prime sponsor.[19] To obtain such consideration, each prime sponsor applicant must submit to the Regional Administrator a preapplication that meets certain requirements specified by the Department.[20]

After being designated as eligible to receive Title I funds, a prime sponsor must submit an application for funds to the Regional Administrator.[21] The application must provide, among other things, for a comprehensive manpower plan.[22] Among the items that must be set forth in the plan are the following: (1) the program objectives and need for assistance, including a description of the geographic area to be served and its economic condition, a description of the labor force to be served, an assessment of job opportunities in the area, and a description of the population groups or significant segments that are most in need of service; (2) the results and benefits expected from the program, including a statement of client training and occupational goals and objectives; (3) the approach to be followed for implementing the program, including a description of the services and activities to be provided and an explanation of the methods and criteria for selecting service deliverers; (4) a description of the linkages with other programs providing manpower and related supportive services within the area; and (5) a description of the prime sponsor's program planning, including the participation of community-based organizations and groups in the program plan.[23] A prime sponsor must also include in the plan the projected level of employment, the number of participants expected to be served by each program activity, and the significant segments of the population and the number of persons of each segment who will be served.[24] ("Significant" segments means those groups of people characterized, if appropriate, by race or ethnicity, sex, age, occupational or veteran status, or other descriptive categories that cause them generally to experience unusual difficulty in obtaining employment and who are most in need of services provided under the act.)[25]

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[14] 29 U.S.C. §812(a)(1)-(5) (Supp. V 1975). See also 29 C.F.R. §95.3 (1976) (effective July 26, 1976) for the Department of Labor's further interpretation of the statutory provisions.

[15] 29 U.S.C. §812(b)(1) (Supp. V 1975).

[16] 29 C.F.R. §95.3(e) (1976) (effective July 26, 1976).

[17] 29 U.S.C. §812(c)(2) (Supp. V 1975).

[18] 29 C.F.R. §94.4(g) (1976) (effective July 26, 1976).

[19] 29 C.F.R. §95.12 (1976) (effective July 26, 1976).

[20] 29 C.F.R. §95.11 (1976) (effective July 26, 1976).

[21] 29 C.F.R. §95.16(a) (1976) (effective July 26, 1976).

[22] 29 C.F.R. §95.14(a) and (b)(2) (1976) (effective July 26, 1976).

[23] 29 C.F.R. §95.14(b)(2)(i)(A)-(C) (1976) (effective July 26, 1976).

[24] 29 C.F.R. §95.14(b)(2)(ii) (1976) (effective July 26, 1976).

A prime sponsor who intends to use any Title I funds for transitional public service employment programs must carry out such programs in keeping with certain provisions of Title II.[26]

Prime sponsor applicants must make public the proposed comprehensive manpower plan 30 days prior to its submission to the Regional Administrator.[27] The publication requirement can be satisfied by publishing a notice of application for the grant and other information in one issue of a newspaper with general circulation in the area to be served under the plan.[28]

Economically disadvantaged, unemployed, and underemployed persons are eligible to participate in Title I programs.[29] "Economically disadvantaged persons" means members of families that receive cash welfare payments or whose total income for the 12 months prior to application in relation to family size is at or below the poverty level designated by the Office of Management and Budget (OMB).[30] "Unemployed persons" means, except for welfare recipients, persons without a job who want and are available for work.[31] A person without a job is one who did not work during the calendar week preceding the week in which eligibility determination is made.[32] In the case of welfare recipients, "unemployed person" means an adult who receives cash assistance from the supplemental security income program (SSI) under Title XVI of the Social Security Act or the aid to families with dependent children program (AFDC) under Title IV–A of that act, or who would be eligible for such cash assistance if both parents were not present in the home.[33] Such persons must also be available for work and either have no job or have a job providing insufficient income to maintain self-support without welfare payments.[34] Veterans who have served on active duty for more than 180 days or who are discharged or released from active duty because of a service-connected disability are eligible, without regard to the requirement that they be unemployed for a calendar week, if they have not obtained employment after their discharge.[35] "Underemployed person" means a person working part-time but seeking full-time work or working part-time and a member of a family whose income in the 12 months prior to application in relation to family size is at or below the OMB poverty level.[36]

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[25] 29 C.F.R. §94.4(yy) (1976) (effective July 26, 1976).

[26] 29 U.S.C. §815(a)(5) (Supp. V 1975). See also 29 C.F.R. §95.14(b)(3)(iii) (effective July 26, 1976) for specific assurances required from prime sponsors using Title I funds to finance transitional public service employment programs.

[27] 29 C.F.R. §§95.15(a)(1) and (b)(2) (1976) (effective July 26, 1976).

[28] 29 C.F.R. §95.15(b)(1) (1976) (effective July 26, 1976).

[29] 29 C.F.R. §95.32(a) (1976) (effective July 26, 1976).

[30] 29 C.F.R. §94.4(s) (1976) (effective July 26, 1976).

[31] 29 U.S.C. §981(a)(12)(A) (Supp. V 1975).

[32] 29 C.F.R. §94.4(ggg)(1) (1976) (effective July 26, 1976).

[33] 29 U.S.C. §981(a)(12)(B) (Supp. V 1975).

[34] *Id.*

[35] 29 C.F.R. §94.4(ggg)(3) (1976) (effective July 26, 1976).

[36] 29 U.S.C. §981(a)(11) (Supp. V 1975); 29 C.F.R. §94.4(fff) (1976) (effective July 26, 1976).

A prime sponsor must establish priorities for program participation taking into account, among other things, the significant segments of the economically disadvantaged, unemployed, and underemployed population within its jurisdiction.[37] Prime sponsors must also give special consideration to the needs of certain categories of veterans.[38]

Prime sponsors may directly provide the training and manpower services included in their plans, or they may enter into contracts, or grants under certain conditions, with other agencies or organizations for these purposes.[39] The training and manpower services provided are expected to be directed primarily toward placing individuals in unsubsidized employment, meaning employment financed by sources other than CETA.[40]

Title II, Public Employment Programs, authorizes funds to develop job opportunities that meet public service needs and are transitional; that is, jobs that are likely to lead to regular unsubsidized employment or opportunities for continued training.[41] Funds may also be used to support other related manpower services and training.[42]

Title II funds are available to qualified prime sponsors under Title I or to Indian tribes on Federal or State reservations[43] having jurisdiction over areas of substantial unemployment.[44] An area of substantial unemployment means, except for Indian tribes or reservations, any area within a prime sponsor's jurisdiction that has a population of at least 10,000 persons, qualifies to receive at least $25,000 in Title II funds, and has an unemployment rate of 6.5 percent or more for 3 consecutive months as determined by the Secretary of Labor at least once each fiscal year. In addition, the units constituting the area must be contiguous.[45] Only the 6.5 percent minimum unemployment rate is a prerequisite for eligibility of an Indian tribe or reservation.[46]

To be determined eligible to receive funds under Title II, potential prime sponsors must follow the same procedures established to receive Title I funds,[47] including submission of a comprehensive Title II plan.[48] The information and procedural requirements for Title II grant applications are similar to those established for Title I,[49] including the mandate to afford the public an opportunity to comment on the Title II plan.[50] If the prime sponsor eligible for Title II is also eligible to receive Title I funds, a separate application for each title is not required; a single grant application may be submitted.[51]

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[37] 29 C.F.R. §95.31(c) (1976) (effective July 26, 1976).

[38] 29 C.F.R. §95.32(e)(1) (1976) (effective July 26, 1976).

[39] 29 U.S.C. §815(a)(3)(B) (Supp. V 1975). See also 29 C.F.R. §98.27(a) (1976) (effective July 26, 1976) for the specific conditions imposed on the use of contracts or grants.

[40] 29 C.F.R. §95.33(a) (1976) (effective July 26, 1976).

[41] 29 C.F.R. §96.23(b)(1)-(2) (1976) (effective July 26, 1976).

[42] 29 U.S.C. §841 (Supp. V 1975).

[43] 29 U.S.C. §844(a) (Supp. V 1975).

[44] 29 C.F.R. §96.3(a) (1976) (effective July 26, 1976).

[45] 29 C.F.R. §94.4(c)(1) (1976) (effective July 26, 1976).

[46] 29 C.F.R. §94.4(c)(2) (1976) (effective July 26, 1976).

[47] 29 C.F.R. §§96.11-12 (1976) (effective July 26, 1976).

[48] 29 C.F.R. §96.14 (1976) (effective July 26, 1976).

[49] Compare 29 C.F.R. §96.14 to §95.14 (1976) (effective July 26, 1976.)

[50] 29 C.F.R. §96.15 (1976) (effective July 26, 1976).

There are certain restrictions on the types of jobs that may be developed and filled under Title II. Among other things, the jobs may not replace, but must be in addition to, positions that would be financed in the course of the ordinary business of the prime sponsor.[52] To the extent feasible, the public services provided by the jobs created must benefit the residents of the area receiving assistance.[53] Jobs must be filled at the entry level in a promotional line until compliance with personnel procedures and collective bargaining agreements has been achieved.[54] As a general rule, not more than one-third of the program participants may be employed in a bona fide professional capacity.[55] To the extent feasible, public service jobs must be in occupational fields that are most likely to expand as unemployment declines.[56] Part-time jobs are permitted only for persons who are unable to work full time because of age, handicap, or other personal factors.[57]

The prime sponsor must allocate equitably the jobs made available under Title II among the State and local public agencies, taking into account the number of unemployed persons in each area and the needs of the agencies.[58] Jobs may also be allotted to private, nonprofit agencies that provide public service employment.[59]

Persons are eligible to participate in Title II financed programs if they reside in an area qualifying for Title II assistance (that is, an area of substantial unemployment as defined above) and have been unemployed for 30 days or are underemployed.[60] "Underemployed" for Title II is defined in the same way as for Title I.[61] "Unemployed" for Title II means a person without a job and available for work, or an adult who receives or whose family receives cash assistance under SSI or AFDC, or who would be eligible for such assistance under certain conditions and is available for work and is either without a job or has a job that provides insufficient income to enable self-support.[62] Being "without a job" means that during the 30 days preceding application, a person worked no more than 10 hours or earned no more than $30 in any calendar week during the 30 days.[63] Veterans who have served on active duty for more than 180 days, or who were discharged or released for a service-connected disability, are eligible upon discharge without regard to the 30-day unemployment requirement if they have not obtained employment after their discharge.[64]

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[51] 29 C.F.R. §96.14(a)(1) (1976) (effective July 26, 1976).

[52] 29 U.S.C. §845(c)(25) (Supp. V 1975). See also 29 C.F.R. §96.24 (1976) (effective July 26, 1976).

[53] 29 U.S.C. §845(c)(3) (Supp. V 1975).

[54] 29 U.S.C.A. §845(c)(24) (West Supp. 1977).

[55] 29 U.S.C. §845(c)(22) (Supp. V 1975).

[56] 29 U.S.C. §845(c)(6) (Supp. V 1975).

[57] 29 U.S.C. §981(a)(7) (Supp. V 1975); 29 C.F.R. §96.23(b) (14) (1976) (effective July 26, 1976).

[58] 29 U.S.C. §845(c)(23) (Supp. V 1975); 29 C.F.R. §96.23(b)(4) (1976) (effective July 26, 1976).

[59] 29 C.F.R. §96.23(b)(5) (1976) (effective July 26, 1976).

[60] 29 U.S.C. §§841, 845(a) (Supp. V 1975).

[61] 29 U.S.C. §981(a)(11) (Supp. V 1975); 29 C.F.R. §§96.27(r), 94.4(fff) (1976) (effective July 26, 1976).

[62] 29 U.S.C. §981(a)(12) (Supp. V 1975); 29 C.F.R. §94.4(hhh) (1)–(2) (1976) (effective July 26, 1976).

[63] 29 C.F.R. §94.4(hhh)(3) (1976) (effective July 26, 1976).

Prime sponsors must give special consideration to certain categories of veterans, to welfare recipients, and to former manpower trainees for whom work opportunities are not otherwise available in the design of their plans and in enrolling persons in Title II programs.[65] Special consideration in public service employment and other Title II-funded activities must also be given to unemployed persons who are the most severely disadvantaged in terms of the length of time they have been unemployed and their prospects for finding employment without assistance from Title II programs.[66] Prime sponsors must also equitably serve the significant segments of the population in their jurisdiction, considering the relative numbers of unemployed persons in each segment.[67]

When units of general local government, or a combination of such units having a population of 50,000 or more, contain or are part of an area of substantial unemployment within the prime sponsor's jurisdiction, such units have a right to administer Title II funds allocable to their geographic areas.[68] If such units elect to exercise this right, they are delegated the functions of "program agents."[69] By a formal, subgrant agreement,[70] the prime sponsor must then distribute Title II funds to each program agent based on the portion allocated to the prime sponsor that was attributable to the program agent's area.[71] A program agent has administrative responsibility for developing, funding, overseeing, and monitoring programs within its area.[72] For areas not administered by program agents, the prime sponsor may subgrant or contract with a variety of public or private organizations.[73] For example, if the prime sponsor were the mayor's office, Title II funds might be awarded to the city's department of public welfare, the school board, the department of health, and the Urban League.

Title VI, Emergency Job Programs, was originally enacted in December 1974 as a temporary, countercyclical, public service employment program.[74] The program, however, was reauthorized and amended by the Emergency Jobs Programs Extension Act in 1976.[75] Like Title II, Title VI makes financial assistance available to prime sponsors to provide transitional employment in jobs providing needed public services and training and manpower services for unemployed and underemployed persons.[76] The program's objective is to enable such persons to obtain unsubsidized employment.[77]

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[64] 29 C.F.R. §94.4(hhh)(5) (1976) (effective July 26, 1976). Unemployed Vietnam era veterans are subject to a slightly different provision.

[65] 29 C.F.R. §96.30 (1976) (effective July 26, 1976).

[66] 29 U.S.C. §845(c)(7) (Supp. V 1975); 29 C.F.R. §96.28 (1976) (effective July 26, 1976).

[67] 29 U.S.C. §§845(c)(2), 848(b) (Supp. V 1975).

[68] 29 U.S.C. §844(d)(1) (Supp. V 1975); 29 C.F.R. §§96.2(c), 94.4(qq) (1976) (effective July 26, 1976).

[69] 29 U.S.C. §844(d)(1) (Supp. V 1975).

[70] 29 C.F.R. §§96.2(c), 96.22(a) (1976) (effective July 26, 1976).

[71] 29 U.S.C. §844(d)(1) (Supp. V 1975); 29 C.F.R. §96.2(c) (1976) (effective July 26, 1976).

[72] 29 U.S.C. §844(d)(2) (Supp. V 1975).

[73] 29 C.F.R. §§96.2(c), 96.23(b)(4)–(5), 96.33(b), 96.36(c), 98.27(a) (1976) (effective July 26, 1976).

[74] Emergency Jobs and Unemployment Assistance Act of 1974, Pub. L. No. 93–567, 88 Stat. 1845 [codified in 29 U.S.C. §§961–966 and scattered sections of 29 U.S.C. (Supp. V 1975)]; *Employment and Training Report, 1977*, p. 45.

[75] Emergency Jobs Programs Extension Act of 1976, Pub. L. No. 94–444, 90 Stat. 1476 [codified in 29 U.S.C.A. (West Supp. 1977)].

Currently, those qualified for fiscal year 1977 as Title I prime sponsors and Indian tribes and bands and groups qualified for the same year under section 302(c)(1) of the act are eligible to receive funds.[78] Prime sponsors must apply for Title VI funds by submitting a grant application to the Regional Administrator that includes a comprehensive Title VI plan.[79] The prime sponsor may append the pertinent part of the Title II plan and provide any additional details necessary to meet the Title VI requirements.[80] Other information and procedural requirements are similar to those established for Title I and Title II grant applications.[81] Public comment on the Title VI plan, however, may be sought at the same time as, rather than 30 days before, the applicant submits its Title VI grant application.[82]

As with Title II, program agents have a right to administer Title VI funds allocable to their jurisdictions, and, unless otherwise specified by the Secretary of Labor, a prime sponsor must distribute its Title VI allotment to such agents in keeping with the Secretary's intent and basis in distributing funds to the prime sponsor.[83] Being an area of substantial unemployment is not a condition for receipt of funds under Title VI; therefore, the definition of program agent for Title VI differs from that for Title II. The term simply means any unit of general local government or combination of such units located within an eligible applicant's jurisdiction that has a population of 50,000 or more. Program agent responsibilities under Title VI are the same as those prescribed for Title II.[84] Also like Title II, prime sponsors may serve residents of areas not served by program agents through grants or contracts with other public or private agencies.[85]

Originally, persons were eligible to participate in the Title VI program if they were unemployed for at least 30 days (for at least 15 days in areas of excessively high unemployment) or underemployed and resided in the area of the prime sponsor.[86] To the maximum extent feasible, preferred consideration was to be given to unemployed persons who had exhausted their unemployment insurance benefits, were ineligible for such benefits, or were unemployed for 15 or more weeks.[87] Although it did not change the basic eligibility requirements, the Emergency Jobs Programs Extension Act of 1976 amended Title VI to formalize the mandate for preferred consideration into a requirement that at least 50 percent of job vacancies occurring after June 30, 1976, be filled by low-income persons who are either long-term unemployed, receive AFDC, or are members of families who receive AFDC.[88] In addition, prime sponsors are required to take reasonable steps to allocate jobs equitably among these categories of persons.[89]

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[76] 29 U.S.C. §962(a) (Supp. V 1975).

[77] *Id.*

[78] 29 U.S.C.A. §962(e) (West Supp. 1977).

[79] 42 Fed. Reg. 2426, 2432–33 (1977) (to be codified in 29 C.F.R. §§99.12, 99.14(a)).

[80] 42 Fed. Reg. 2426, 2432 (1977) (to be codified in 29 C.F.R. §99.12(c)(2)(i)).

[81] 42 Fed. Reg. 2426, 2432 (1977) (to be codifed in 29 C.F.R. §99.12). Compare with 29 C.F.R. §§95.14 and 96.14 (1976) (effective July 26, 1976).

[82] 42 Fed. Reg. 2426, 2433 (1977) (to be codified in 29 C.F.R. §99.13(a)).

[83] 29 U.S.C. §§962(c), 844(d)(1) (Supp. V 1975); 42 Fed. Reg. 2426, 2431 (1977) (to be codifed in 29 C.F.R. §99.2(e)(1)–(2)).

[84] 29 U.S.C. §§962(c), 844(d)(2) (Supp. V 1975).

[85] 42 Fed. Reg. 2426, 2431 (1977) (to be codifed in 29 C.F.R. §99.2(e)(1)).

[86] 29 C.F.R. §§99.36(a)(1), 99.53(a) (1976). An area of excessively high unemployment is one that has an average unemployment rate in excess of 7 percent for the most recent 3 consecutive months. 29 C.F.R. §99.50(b)(1) (1976).

[87] 29 U.S.C. §962(d) (Supp. V 1975). Federal regulations, though repeating the statutory provi-

The 50 percent requirement applied to funds reserved by prime sponsors to sustain the number of Title II and Title VI public service job holders on board as of June 30, 1976, through fiscal year 1977.[90] Prime sponsors were additionally required to devote their remaining funds to public service jobs in new projects and activities for which only low-income and long-term unemployed or AFDC recipients would be eligible.[91] The duration of such projects or jobs is limited to 1 year.[92] The act imposes no time restrictions on an individual's participation, but Federal regulations strongly encourage a 1-year limit.[93]

According to the Department of Labor, the effects of these new requirements were deferred until well after June 30, 1976, because the amendments were not enacted until October 1, 1976, and final Federal regulations did not go into effect until January 10, 1977.[94]

Most requirements governing public service employment programs under Title II also apply to Title VI.[95] Part-time jobs have been permitted only for individuals

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sion, added a proviso that, notwithstanding this provision, if persons met the eligibility requirements, they could be enrolled in Title VI-funded programs. 29 C.F.R. §99.36(d) (1976). The regulations also provided an additional list of groups that were to be given "special" consideration: certain categories of veterans, the most severely disadvantaged in terms of length of unemployment and prospects for employment without Title VI assistance, and former manpower trainees in Title VI public service jobs. 29 C.F.R. §99.37(a) (1976). It should be noted that the groups additionally designated in regulations might overlap in many instances with the statutorily prescribed groups.

[88] Emergency Jobs Programs Extension Act of 1976, Pub. L. No. 94 444, §5(a), 90 Stat. 1477–78, [codified in 29 U.S.C.A. §§967(c), 968(a) (West Supp. 1977)]. "Long term unemployed" means an individual who has been receiving unemployment compensation for 15 or more weeks, who is not eligible for such benefits and has been unemployed for 15 or more weeks, or who has exhausted unemployment compensation benefits. These were the same groups singled out by the earlier act for preferred consideration. "Low-income" means that an individual is not a member of a household that has a current gross family income, adjusted to an annual basis (exclusive of unemployment compensation and other public payments which such individual will be disqualified from receiving by reason of employment under Title VI) at a rate exceeding 70 percent of the lower living standard income level.

The Department of Labor, in Federal regulations implementing the 1976 amendments and republishing the remaining applicable Title VI regulations, added certain categories of veterans to the prior basic eligibility rules. 42 Fed. Reg. 2426, 2536 (1977) (to be codified in 29 C.F.R. §99.42(b) (2)).

[89] 29 U.S.C.A. §968(c) (West Supp. 1977).

[90] 29 U.S.C.A. §§967(a) and (c) (West Supp. 1977).

[91] 29 U.S.C.A. §967(b) (West Supp. 1977). See also 42 Fed. Reg. 2426, 2430 and 2435 (1977) (to be codified in 29 C.F.R. §§99.1(d), 99.40(b) (1)).

[92] *Id.*

[93] 42 Fed. Reg. 2426, 2430 (1977) (to be codified in 29 C.F.R. §99.1(e)).

[94] Carin Ann Claus, solicitor, U.S. Department of Labor, letter to Eileen Bradley, Feb. 17, 1978.

[95] 29 U.S.C. §962(c) (Supp. V 1975). But see also 29 U.S.C. §§964(a)–(b) (Supp. V 1975) in regard to areas of excessively high unemployment.

unable to work full-time because of age, handicap, or other factors.[96] The 1976 amendments, however, emphasized the need for providing such jobs by requiring prime sponsors, in regard to the low-income and long-term unemployed or AFDC recipients to give special consideration to the household obligations of program applicants and to alternative working arrangements including flexible hours, shared time, and part-time jobs, particularly for the parents of young children and for older persons.[97]

The Titles I, II, and VI programs are administered by the Employment and Training Administration of the Department of Labor. Although all areas of the country are covered by these titles, the number of prime sponsors has increased since the program's inception because of population changes and other factors.[98] Table 4.1 shows the types and numbers of prime sponsors for fiscal years 1975, 1976, and 1977, and table 4.2 presents the appropriation levels and the number of persons served for those years.

Summary of the Record

Program Participants

National data on the ages of CETA enrollees were compared with the age distribution of the unemployed population, which was selected as the base for this analysis because it was considered to be the best available single measure of persons eligible to participate in the CETA program. Unemployment data are also used by the Department of Labor to determine whether prime sponsors are serving the target groups they should be, as shown by a recent Department of Labor field memorandum on the CETA grant funding process. The memorandum requires that prime sponsors in the narrative description of their annual plan for Titles I and II:

> . . .identify. . .the percent which the unemployed population within the prime sponsor's jurisdiction constitutes of each of. . .[specified] demographic groups. . . .
>
> Describe the significant segments the prime sponsor has targeted for service. . . .
>
> . . .Where service to the identified significant segments results in a plan of service which varies by more than 15 percent points from the demographic breakout [of the unemployed population, prime sponsors must] justify these variations.[99]

It is acknowledged that using data on the unemployed as the eligible population base for CETA has certain limitations. Unemployment is not the sole eligibility criterion for participation in programs funded by Title I, Title II, or Title VI. Economically disadvantaged and underemployed persons are also eligible under Title I. Title II requires that persons reside in areas of substantial unemployment and also permits underemployed

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[96] 29 U.S.C. §981(a)(7) (Supp. V 1975).

[97] 29 U.S.C.A. §968(d) (West Supp. 1977).

[98] *Employment and Training Report*, 1977, p. 45.

[99] U.S., Department of Labor, Employment and Training Administration, *Field Memorandum No. 324-77*, "CETA Grant Funding Process," June 24, 1977, attachment II.

Table 4.1
Distribution of Prime Sponsors by Type, Fiscal Years 1975, 1976, and 1977

	Total	Cities	Counties	Consortia	Rural CEPS[a]	Balance of State
FY 1975	403	58	156	134	4	51
FY 1976	431	62	175	140	4	50
FY 1977	444	65	179	145	4	51

[a] CEP=Concentrated Employment Program

Source: U.S., Department of Health, Education, and Welfare, and Department of Labor, *Employment and Training Report of the President* (1977), p. 45.

Table 4.2
Appropriation Levels and Number of Persons Served under CETA Titles I, II, and VI Programs, Fiscal Years 1975, 1976, and 1977

Year/Program	Appropriation Levels (in thousands)	No. of Persons Served
1975		
Title I	1,580,000	1,079,904
Title II	400,000	197,341
Title VI	875,000	153,737
1976		
Title I	1,580,000	1,620,915
Title II	400,000	238,439
Title VI	2,825,000	474,137
1976 Transition Quarter		
Title I	395,400	Not Available
Title II	100,000	Not Available
Title VI	–0–	Not Available
1977		
Title I	1,880,000	1,499,427
Title II	1,540,000[a]	336,220
Title VI	6,847,000[a]	575,526

[a] Funds were appropriated in fiscal year 1977 to support public service jobs through fiscal year 1978.

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

residents to enroll in the program. Title VI places considerable emphasis on services to the low-income, long-term unemployed and AFDC recipients. Finally, the definition of unemployed persons for Title I differs from that for Titles II and VI.

The Commission attempted to assess the extent to which these factors would influence the age composition of those eligible to participate in CETA program; but it was not possible to determine the age distribution of economically disadvantaged and underemployed persons or thus determine the extent to which inclusion of these persons would change the composition of program eligibles.

Available data on long-term unemployed persons indicate that they tend to be concentrated among the older age groups compared to the general unemployed population. In 1977, the Department of Labor published the results of 1975 recipients of benefits paid under two programs that were established in 1974 to assist the long-term unemployed: (1) the Federal supplemental benefits program (FSB), which provided additional benefits to unemployed persons who had exhausted their entitlements to regular and extended benefits under the permanent unemployment compensation programs;[100] and (2) the special unemployment assistance program (SUA), which provided benefits during periods of high unemployment to assist persons who are ineligible for unemployment benefits under any other State or Federal law.[101] The study reported:

> FSB recipients tend to be older than other groups of unemployed people. The average age of FSB recipients was 40 years, compared with the average age of 36 for recipients of EB [extended benefits], and 38 for job losers unemployed 27 weeks or more. . . .
>
> The relatively higher incidence of women and of older workers among beneficiaries of EB and among exhaustees of regular UC [unemployment compensation] programs than among other groups in the labor force has also been noted in other studies. It stems partly from lower UC eligibility rates among younger workers and may also be the result of weaker economic opportunities for older workers.[102]

The average age of SUA recipients was also 40 years. The study found that "both SUA men and women were older than their counterparts among job losers generally."[103] Data on the duration of unemployment by age presented in table 4.3

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[100] Emergency Unemployment Compensation Act of 1974, Pub. L. No. 93-572, 88 Stat. 1869 (codified at 26 U.S.C. §3304 (Supp. V 1975)).

[101] Emergency Jobs and Unemployment Assistance Act of 1974, Pub. L. No. 93-567, Title II, §201, 88 Stat. 1850 [codifed at 26 U.S.C. 3304 (Supp. V 1975)]. Title II was most recently amended in 1976 by the Emergency Jobs Programs Extension Act of 1976, Pub. L. No. 94-444, §6, 90 Stat 1480 [codified in 26 U.S.C.A. §3304 (West Supp. 1977)].

[102] U.S., Department of Labor, Employment and Training Administration, *A Report on 1975 Recipients of Federal Supplemental Benefits and Special Unemployment Assistance*, prepared by Mathematica, Inc. (1977), p. 11 (hereafter cited as a *A Report of FSB and SUA*).

[103] Ibid., p. 20.

Table 4.3
Mean Duration of Unemployment in Weeks for Persons Aged 16 or older by Age, Fiscal Year 1976

Age Group	Mean Number of Weeks
All Ages	16.0
16-19	9.6
20-24	14.8
25-34	17.0
35-44	18.5
45-54	21.2
55-64	22.6
65+	24.8

Source: U.S., Department of Labor, Bureau of Labor Statistics, unpublished data from the Current Population Survey.

show that persons have a longer duration of unemployment as they grow older.[104]

Prime sponsors must give special consideration to those individuals, among others, most in need of training or employment as determined by their length of unemployment.[105] The findings of the DOL-sponsored study and the data on the duration of unemployment suggest that if prime sponsors are carrying out this mandate, CETA enrollees might be expected to include a significant number of older persons.

Using unemployment statistics is also somewhat problematic because they do not reflect all persons who are actually unemployed. The civilian labor force equals the combination of the employed and the unemployed populations.[106] Persons are counted as unemployed if they are without jobs during the week in which the Current Population Survey is conducted, have made specific efforts to find employment sometime during the prior 4 weeks, and are presently available for work. Individuals who are on layoff or who are waiting to start a new job (within 30 days) are also counted.[107] The count of unemployed persons does not, however, include persons who report that they want work but are not engaged in active job search because they believe they cannot find any jobs. These "discouraged workers" are classified as "not in the labor force," which means they do not get counted with the unemployed.[108]

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[104] Data for fiscal year 1976, are for the 12-month period, excluding the transition quarter. The mean duration of unemployment was determined by averaging the means reported for the quarterly averages. Although this may not be the exact mean for the fiscal year, it was suggested by Bureau of Labor Statistics staff as the closest estimate available. Deborah P. Klein, Bureau of Labor Statistics, Department of Labor, telephone interview in Wash., D.C., Jan. 12, 1978.

[105] 29 U.S.C. §§845(c)(7), 815(a)(5), 962(d) (Supp. V 1975); 29 U.S.C.A. §967(c), 968(a) (West Supp. 1977).

[106] U.S., Department of Labor, Bureau of Labor Statistics, *NEWS*, "The Employment Situation: December 1977," Jan. 11, 1978, explanatory note. Labor force, total employment, and unemployment data are derived from the Current Population Survey, a sample survey of households conducted each month by the Bureau of the Census. "Employed persons" means: wage and salary workers (including private household workers), the self employed, unpaid family workers, and persons "with a job but not at work" and not paid for the period absent. Persons who worked at more than one job during the week in which the survey is

According to a 1976 report from the Departments of Health, Education, and Welfare and Labor, 1975 saw a record high of discouraged workers:

> Discouragement was most prominent, as usual, among adult women and younger workers—two groups that in general have a less permanent attachment to the labor force and often face constraints on the hours, locations or permanency of the jobs they can take. . . .However, older men also show a significant degree of discouragement. Members of this older worker group appear to perceive discrimination as an important factor in their labor market situation, since the majority in 1975 reported their reason for not seeking work as a belief that potential employers thought they were too old.[109]

Secretary of Labor Ray Marshall told the Commission that it can be expected that persons 45 or over make up a large number of the discouraged workers who have withdrawn from the work force and therefore do not appear in unemployment statistics.[110] The Department of Labor-sponsored study of FSB and SUA recipients cited above also suggested that young persons and older persons are among the "discouraged workers." These were the only age-based groups cited. The study reported:

> Of those FSB recipients not in the labor force, about half said they wanted a job and of these, over half said they were not looking for work for reasons which would classify them as discouraged workers—defined as those who said they wanted jobs but were not looking because they believed that no work was available; that they could not find work; that they lacked education or skills; that they were too young or too old; or that they suffered from personal handicaps in finding work. Most of the women not in the labor force reported their current activity to be keeping house, while one-fourth of the men said they were retired. The

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conducted or otherwise appear on more than one payroll are counted only once in the household survey and are classified in the job at which they worked the greatest number of hours.

[107] Ibid. Eligibility for unemployment insurance benefits or any kind of public assistance is not a prerequisite to being counted as unemployed.

[108] Ibid., p. 3.

[109] U.S., Department of Labor, and Department of Health, Education, and Welfare, *Employment and Training Report of the President* (1976), pp. 29–30 (hereafter cited as *Employment and Training Report, 1976*).

[110] Ray Marshall, Secretary of Labor, testimony, *Hearing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Sept. 26–28, 1977, vol. I, p. 59, (hereafter cited as *Washington, D.C. Hearing*).

> proportions of those who wanted a job and of those who were discouraged workers among FSB recipients not in the labor force were much higher than the corresponding proportions among those not in the labor force in the population as a whole, because of FSB recipients' recent labor market attachment.[111]

Thus, younger and older persons are not likely to be accurately reflected in unemployment data.

Even with these qualifications, the Commission believes that unemployment data represent the best available measure of the population eligible for the CETA programs to determine whether various age groups participate in CETA programs at the levels that might be expected, given their representation in the eligible population.

National data on persons enrolled in the Titles I, II, and VI programs and on the unemployed population by age for fiscal years 1975, 1976, and 1977 are presented in table 4.4. The age categories shown are those that the Department of Labor requires prime sponsors to use in their reporting. These data show that certain age groups have been consistently underrepresented in each program in comparison to their representation in the unemployed population.

In the Title I program, persons under 19 and 19 to 21 have been overrepresented, while those 22 or over have been underrepresented. In both fiscal years 1975 and 1976, the proportion of Title I enrollees under 19 was more than twice their proportion of the unemployed population. Persons 19 to 22 have represented a higher proportion of Title I enrollees than their proportion of the unemployed population for each of the three fiscal years. Persons 22 to 44 have been underrepresented in the Title I program each year, compared to their representation in the unemployed population; however, the disparities have declined each year. In fiscal year 1975, they represented 46.1 percent of the unemployed population and 32.1 percent of Title I enrollees; in fiscal year 1976, 46.6 percent of the unemployed and 36.4 percent of the enrollees; and in fiscal year 1977, 47.2 percent of the unemployed and 40.7 percent of the enrollees.

For fiscal years 1975 and 1976, the percentage of the unemployed population aged 45 or over was nearly three times their representation among Title I enrollees. In 1977 a slight decline in unemployment coupled with a slight increase in participation reduced that disparity factor to nearly two and one-half.

An examination of each subgroup of those 45 or over reveals similar disparities, with those 55 to 64 faring less well than those 45 to 54 and those 65 or over. In fiscal year 1975, persons 45 to 54 were underrepresented by a factor of 3. This declined to 2.7 in fiscal year 1976 and to just over 2.3 in 1977, when a decline in unemployment also occurred. The age group 55 to 64 was underrepresented in both 1976 and 1977 when unemployment declined and participation rose. Those aged 65 or over maintained a consistent proportion of the unemployed for the 3

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[111] *A Report on FSB and SUA*, p. 15.

Table 4.4

Percent Distribution of the Unemployed Population and CETA Titles I, II, and VI Enrollees by Age, Fiscal Years 1975, 1976, and 1977

Age Group	Unemployed Population[a]	Title I Enrollees[b]	Title II Enrollees[b]	Title VI Enrollees[b]
FY 1975				
All Ages	100.0%	100.0%	100.0%	100.0%
Under 19	18.0	41.4	6.0	3.6
19-21	16.8	20.3	18.1	17.6
22-44	46.1	32.1	62.6	64.8
45-54	10.8	3.6	8.4	9.2
55-64	6.4	1.9	4.0	4.1
65+	2.0	0.8	0.8	0.7
FY 1976				
All Ages	100.0%	100.0%	100.0%	100.0%
Under 19	17.1	35.9	4.4	4.6
19-21	16.5	20.9	17.6	17.4
22-44	46.6	36.4	64.1	64.2
45-54	10.9	4.0	8.9	8.7
55-64	6.8	1.9	4.2	4.3
65+	2.1	0.8	0.8	0.8
FY 1977				
All Ages	100.0%	100.0%	100.0%	100.0%
Under 19	17.8	30.7	4.6	4.3
19-21	16.4	21.1	15.8	16.0
22-44	47.2	40.7	64.3	64.8
45-54	10.1	4.3	9.5	9.2
55-64	6.4	2.3	4.8	4.7
65+	2.0	1.0	1.0	0.9

Source: [a] U.S., Department of Labor, Bureau of Labor Statistics, Unpublished Data.
[b] U.S., Department of Labor, Employment and Training Administration, unpublished data.

years. In fiscal years 1975 and 1976, they were underrepresented by a factor of 2.5 and in 1977, by a factor of 2.

The proportional participation levels for those under 19 decreased over the 3 years. Representation of all other age groups increased to varying degrees. The cause of the decline in the under 19 group could not be determined. It may reflect a change in prime sponsors' emphases in the Title I program or the presence of a large number of hard-to-place persons under 19 in 1975 who have simply "aged out" of that age group.

The age distribution of Titles II and VI enrollees during the 3-year span has been quite different in general from that for Title I. Whereas in Title I all age groups except those under 22 were underrepresented, in Titles II and VI all groups but those 22 to 44 were underrepresented compared to their representation in the unemployed population. In all three fiscal years, the proportion of enrollees 22 to 44 has been over 1.3 times their proportion of the unemployed population. The annual proportions of persons under 19 enrolled in each program has been, except for Title II in 1975, less than one-third of their representation in the unemployed population. The representation of those 45 to 54 in the Titles II and VI programs, when compared to Title I, has more closely approximated their representation among the unemployed; however, this age group is still underrepresented. Similarly, the ratio for those 55 to 64 in Titles II and VI also compared better than for Title I, but this group, too, was underrepresented. The Titles II and VI enrollment figures for those 65 or over are virtually the same as for Title I. Persons 19 to 21 were generally more favorably represented in the Titles II and VI program than in the Title I program compared to their presence in the unemployed population.

These data suggest that younger persons—those under 22—are being placed primarily in the Title I program in which funds are concentrated on training activities, and that, except for those 65 or over, persons 22 or over are being enrolled primarily in the Titles II and VI programs, which support primarily public service employment. Persons 65 or over are represented in all three programs at substantially the same proportions.

Examination of the participation of different age groups aggregated for all three CETA programs shows that persons 45 or over are still represented in the programs at a lower level than their presence in the unemployed population. (See table 4.5.) The proportion of all enrollees in the programs under 19 is just over 1 1/2 times their proportion in the unemployed population—26.5 percent of all program enrollees and 17.1 percent of the unemployed population. The proportion of enrolled persons 19 to 21 and 22 to 44 is close to their representation in the unemployed population. At age 45 the ratio of persons enrolled to those unemployed declines sharply. Persons in each of the age groups over 44 are enrolled at less than half their proportion of the unemployed population.

Because the Department of Labor requires prime sponsors to report participants between the ages of 22 and 44 as one category, little information is avail-

Table 4.5

Percent Distribution of the Unemployed Population and Aggregate of CETA Titles I, II, and VI Enrollees by Age, Fiscal Year 1976

Age Group	Unemployed Population[a]	Enrollees in Titles I, II, and VI[b]
All Ages	100.0%	100.0%
Under 19	17.1	26.5
19-21	16.5	19.9
22-44	46.6	44.8
45-54	10.9	5.4
55-64	6.8	2.6
65+	2.1	0.8

Source: [a] U.S., Department of Labor, Bureau of Labor Statistics, unpublished data.

[b] U.S., Department of Labor, Employment and Training Administration, unpublished data.

able to show whether enrollees in this category are spread throughout the age group or concentrated around a narrower age range. Some data were collected as part of a Department of Labor-sponsored study of new enrollees in calendar year 1975 in the employability development (basically training) and public service employment programs. The study indicated that most of the new enrollees reported in the 22 to 44 age group were actually under 30. In each quarter of the calendar year, approximately 67 percent of new enrollees in those programs who were reported as 22 to 44 were under 30.[112]

In addition to the national data on participants in the Titles I, II, and VI programs, Commission staff reviewed data on enrollees in each program for each of the nine sites visited during the field study and as part of the public hearings. These data, presented in table 4.6, were not compared with data on the unemployed population for each site because they were unavailable entirely or were unavailable for the same age categories or periods of time used by prime sponsors to report their enrollment data. The enrollment data, however, generally conform to the patterns seen in the national data.

Data for the Title I program in each site show that the programs concentrate on persons under 45. In all but one site, less than 10 percent of Title I enrollees were 45 or over. For each site, participation was fairly equally divided between persons

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[112] U.S., Department of Labor, Employment and Training Administration, *Continuous Longitudinal Manpower Survey, Report No. 4* prepared by Westat, Inc. for the Office of Policy, Evaluation, and Research (1976), pp. 3–13 and 3–15.

Table 4.6

Percent Distribution of Enrollees in CETA Titles I, II, and VI Programs in Field Study and Public Hearing Sites, by Age, Fiscal Year 1976

Program/ Age Group	Miami	Denver	San Francisco	Seattle	Maine[a]	Jackson	San Antonio	Chicago	St. Louis
Title I									
All Ages	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under 19	13.2	16.2	27.7	32.0	9.9	28.1	43.7	11.6	13.7
19-21	19.5	25.7	17.3	21.7	28.7	25.1	17.7	35.2	22.9
22-44	49.1	55.3	50.6	43.0	54.3	41.8	31.1	46.2	57.6
45-54	10.0	2.4	2.7	2.7	4.8	2.5	6.5	3.0	3.5
55-64	5.7	0.4	1.2	0.6	2.1	1.7	0.8	1.6	1.1
65 +	2.5	0.0	0.4	0.0	0.3	0.8	0.1	2.4	1.1
Title II									
All Ages	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under 19	3.0	6.1	1.1	2.4	0.8	8.4	5.2	2.1	0.4
19-21	18.3	23.9	9.2	11.0	12.5	25.3	20.9	14.9	13.1
22-44	63.8	64.0	80.4	74.4	67.2	60.7	64.4	69.4	79.9
45-54	9.9	5.7	6.3	7.3	11.1	5.1	6.8	8.9	5.3
55-64	4.8	0.3	2.5	4.4	7.0	0.6	2.4	3.2	1.4
65 +	0.2	0.0	0.5	0.5	1.4	0.0	0.4	1.5	0.0
Title VI									
All Ages	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under 19	3.3	6.5	0.9	3.4	0.7	7.7	5.2	2.8	2.6
19-21	15.2	18.1	9.8	12.0	10.7	19.9	21.3	15.8	16.0
22-44	66.1	68.4	80.3	73.8	70.6	62.8	65.0	62.8	70.8
45-54	11.1	5.4	6.5	7.0	9.8	6.8	6.1	13.3	7.6
55-64	3.9	1.6	2.1	3.5	6.7	2.7	2.2	4.5	3.0
65 +	0.4	0.1	0.5	0.3	1.5	0.0	0.2	0.9	0.0

[a] During fiscal year 1976, Augusta, Maine (the site visited by Commission staff) was part of Maine's balance-of-State program. In fiscal year 1977, however, Kennebec County, which includes Augusta, became an independent prime sponsor.

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

under 22 and those 22 to 44. In the Title II and Title VI programs, persons between 22 and 44 constituted over 60 percent of the enrollees in every site. In three of the nine Title II sites and four Title VI sites, over 70 percent of the enrollees were between 22 and 44. Persons 45 or over were a smaller percentage of enrollees in the program in most of the sites than in the national statistics.

Seattle (King-Snohomish County) and Denver reported no Title I enrollees aged 65 or over. Denver, Jackson, and St. Louis reported no enrollees 65 or older for Title II, and Jackson and St. Louis reported the same for Title VI. As with the national data, site participation data were generally not available for narrower age categories within the 22 to 44 age group. Several administrators of Titles I, II, and VI programs, however, reiterated the finding of the national study conducted for the Department of Labor that persons reported by prime sponsors to be in the 22 to 44 age group were, in fact, concentrated in the 22 to 29 age range.

The director of public service employment for St. Louis told Commission staff that participants in his program who were reported in the 22 to 44 age group were actually concentrated in the 25 to 29 age group.[113] In St. Louis, 57.6 percent of the Title I enrollees, 79.9 percent of the Title II enrollees, and 70.8 percent of the Title VI enrollees were reported in the 22 to 44 age category. The field services coordinator for a Title I training program in St. Louis agreed that enrollees reported as 22 to 44 are generally under 30, saying that it was her impression that the concentration of walk-in clients in her program are under 30.[114]

Participant characteristic data covering a 1-month period that identified enrollment of persons 22 to 44, 25 to 34, and 35 to 44 were available for two Title I programs in Seattle. They showed that enrollees in these programs were concentrated under the age of 35.[115] These data are presented in table 4.7.

Narrow Interpretation of Broad Statutory Goals

Although Title I, Title II, and Title VI of the Comprehensive Employment and Training Act all authorize both training and public service employment services, prime sponsors have concentrated their Title I program efforts on training and manpower services and Title II and VI on public service employment. Less than 5 percent of Title I enrollees were in public service employment activities in fiscal year 1976.[116] During the same period, 96 percent of the Title II enrollees and 84 percent of the Title VI enrollees placed in any activity were in public service employment.[117]

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[113] Joseph Kelly, director of public service employment, Office of Manpower of the City of St. Louis, interview in St. Louis, Mo., Apr. 7, 1977 (hereafter cited as Kelly Interview).

[114] Beverly Riola, field services coordinator, Office of Manpower of the city of St. Louis, Arthur Kennedy Skills Center, interview in St. Louis, Mo., Apr. 6, 1977 (hereafter cited as Riola Interview).

[115] State of Washington, King-Snohomish Manpower Consortium, *Batch Control and Characteristic Summary: Seattle OIC*, February 1977; State of Washington, King-Snohomish Manpower Consortium, *Batch Control and Characteristic Summary: ES OJT*, March 1977.

[116] *Employment and Training Report, 1977*, pp. 45–46.

[117] Ibid., p. 46.

Table 4.7
Number and Percent Distribution of CETA Title I Enrollees in Two Programs by Age, Seattle

Age Group	Enrollees, Program A February, 1977[a]		Enrollees, Program B March, 1977[b]	
	Number	Percent	Number	Percent
All Ages	1001	100.0%	163	100.0%
Under 19	99	9.9	6	3.7
19-21	261	26.1	52	31.9
22-24	216	21.6	24	14.7
25-34	310	30.9	62	38.0
35-44	83	8.3	12	7.4
45 or over	32	3.2	7	4.3

Source: [a] State of Washington, King-Snohomish Manpower Consortium, *Batch Control and Characteristic Summary: Seattle OIC*, February, 1977.
[b] State of Washington, King-Snohomish Manpower Consortium, *Batch Control and Characteristic Summary: ES OJT*, March, 1977.

Title I prime sponsors have wide discretion in the choice and design of their manpower training and services programs.[118] The act proscribes discrimination on the basis of race, creed, color, national origin, sex, age, political affiliation, or belief.[119] Federal regulations provide that prime sponsors shall not include, in the design of their programs, traditional hiring practices that result in discrimination on these grounds.[120] Among the basic but not exclusive types of manpower programs a prime sponsor may provide are the following:

- Classroom training, [which] is any training conducted in an institutional setting designed to provide individuals with technical skills and information required to perform a specific job or group of jobs. It may also include training designed to enhance the employability of individuals by upgrading basic skills. . . .

- On-the-job training (OJT), [which] is training conducted in a work environment designed to enable individuals to learn a bona fide skill and/or qualify for a particular occupation through demonstration and practice. . .OJT may involve individuals at the entry level of employment or be used to upgrade present employees into occupations requiring higher skills. . . .

- Work experience, [which] is a short-term and/or part-time work assignment with a public employer or a private non-profit employing agency and is designed to enhance the employability of individuals who have either never worked or who recently have not been working in the competitive labor population for an extended period of time. . . .[121]

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[118] 29 U.S.C. §811 (Supp. V 1975).

[119] 29 U.S.C. §§983(1) (Supp. V 1975).

[120] 29 C.F.R. §95.33(a)(1976) (effective July 26, 1976).

The regulations further describe work experience activities in terms of activities for youth and adults. Work experience activities for youth include part-time employment for students attending school, short-term employment for students during the summer, short-term employment for out-of-school youth adjusting to a work setting and in transition from school to employment, short-term employment for recent graduates, and short-term or part-time employment for those youth who have no definite occupational goal.[122]

Work experience for adults includes part-time or short-term employment for the chronically unemployed, retired persons, recently discharged military individuals, handicapped individuals, institutional residents and inmates, and others who recently have not been working in the competitive labor population for extended periods of time.[123]

Clearly, the regulations allow prime sponsors the flexibility to design their training and manpower services programs to meet the needs not only of new entrants to the labor force, but also of persons who have worked and whose skills may need upgrading. The Commission found, however, that many prime sponsors did not consider the training and manpower services programs to be appropriate for all age groups. Rather, they considered such activities to be appropriate for youth. Similarly, public service employment was not considered an activity appropriate for all age groups, but for "employable" persons between 22 and 44. As shown by the national data on enrollees in the Title I program, persons under 22 comprised more than half of all enrollees in fiscal years 1975, 1976, and 1977, although they represented approximately 34 to 35 percent of the unemployed population each year. (See table 4.8.)

Review of prime sponsors' Title I comprehensive manpower plans indicated that extensive participation by youth under 22 is planned by program administrators and is not merely the result of choices made by eligible individuals. As part of their plans, prime sponsors must identify the significant segments of the population most in need of services in their jurisdictions and set forth the number of individuals to be served from each segment.[124] Commission staff found, in its review of Title I plans for the six sites visited in the field study, that youth were identified as a priority in five of the six sites. In the sixth site, general categories (economically disadvantaged, welfare recipients, heads of household, veterans, and former manpower trainees) had been chosen, but the manpower plan noted that within these categories, women and youth have special problems and, by implication, deserve special assistance. Other age groups were identified as Title I priorities in three

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[121] 29 C.F.R. §95.33(d)(1)-(2) and (4)-(5) (effective July 26, 1976).

[122] 29 C.F.R. §95.33(d)(4)(iii) (1976) (effective July 26, 1976).

[123] 29 C.F.R. §95.33(d)(4)(iv) (1976) (effective July 26, 1976).

[124] 29 C.F.R. §95.14(b)(2)(i)(A)(2)(v) and (ii) (1976) (effective July 26, 1976).

Table 4.8

Percent Distribution of the Unemployed Population and CETA Title I Enrollees by Age, Fiscal Years 1975, 1976, and 1977

Age Groups	Unemployed Population[a]			Title I Enrollees[b]		
	FY 1975	FY 1976	FY 1977	FY 1975	FY 1976	FY 1977
All Ages	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under 19	18.0	17.1	17.8	41.4	35.9	30.7
19-21	16.8	16.5	16.4	20.3	20.9	21.1
22-44	46.1	46.6	47.2	32.1	36.4	40.7
45-54	10.8	10.9	10.1	3.6	4.0	4.3
55-64	6.4	6.8	6.4	1.9	1.9	2.3
65 +	2.0	2.1	2.0	0.8	0.8	1.0

Source: [a] U.S., Department of Labor, Bureau of Labor Statistics, unpublished data.
[b] U.S., Department of Labor, Employment and Training Administration, unpublished data.

sites: high school dropouts 22 to 44 in one site, persons 25 to 34 in another site, and older workers in a third site. As shown in table 4.9, the number of persons projected to be trained in these other age groups was considerably lower than the number established for youth.

In contrast, only one prime sponsor in the six sites identified youth or any other specific age group as a "significant segment" to whom the Title II and Title VI public service employment programs would be targeted. Concentration was on serving heads of households, veterans, and economically disadvantaged persons.

This selection of different age groups as "significant segments" in the Titles I, II, and VI programs suggests that the prime sponsors considered Title I programs more appropriate for young persons and Title II and VI for other non-age-based groups. All of the prime sponsors identified youth as an important target group, but focused on them only in the training program. Prime sponsors and others also stated in interviews and testimony that training was an activity appropriate for youth and that public service employment was for "employable" persons between 22 and 44.

The director of the King-Snohomish Manpower Consortium stated that 45 percent of the participants in his Title I program were 14 to 15, and that his agency was trying to move toward the "older population" (meaning persons in their late 20s) but that doing so would result in tremendous pressure from low-income parents. He defended his training program's emphasis on youth, saying that it is normal to start at the "front end" and design training for young persons—high

Table 4.9
Significant Segments Selected for Titles I, II, and VI Programs at Six Sites

	Title I		Title II		Title VI	
Site	Significant Segments	No. of Persons	Significant Segments	No. of Persons	Significant Segments	No. of Persons
Jackson, Mississippi[a]	Unemployed Heads of Household	456	Unemployed Male Heads of Household	53	AFDC	134
	AFDC Recipients	458	Unemployed Female Heads of Household	25	Other Title VI Requirements	31
	Youth 16-21	860			Blacks	161
	Economically Disadvantaged	1375				
	Veterans	61				
	High School Dropouts (22-44)	120				
San Antonio, Texas[b]	Heads of Household	3973	Heads of Household	610	Heads of Household	548
	Handicapped	280	Disadvantaged	205	Disadvantaged	450
	Public Assistance Recipients	545	Veterans	400	Veterans	281
	Veterans	1166				
	AFDC Recipients	766				
	Disadvantaged Youth (16-21)	1366				
	Ex-offenders	407				
King-Snohomish County (Seattle, Wash.)[c]	Minorities	6173	Persons Unemployed 15 weeks	Not Available	Persons Unemployed 15 weeks	Not Available
	Women	6310	Low-income		Low-income	
	Persons 16-24	9012	Discouraged Workers		Discouraged Workers	
	Persons 25-34	2299				
State of Maine[d]	Economically Disadvantaged	2547	Economically Disadvantaged	518	Not Available	Not Available
	Welfare Recipients	566	Welfare Recipients	161		
	Heads of Household	2123	Heads of Household	269		
	Veterans	283	Veterans	161		
	Former Manpower Trainees	283	Former Manpower Trainees	108		
St. Louis Missouri[e]	Underemployed	1918	Former Manpower Trainees	217	Not Available	Not Available
	Welfare Recipients	1600	Veterans	242		
	Youth and Others	2300	Disadvantaged	329		
	Unemployed	2800	Welfare Recipients	174		
	Veterans	320				
Chicago, Illinois[f]	Black	9545	Minorities	2350	Not Available	Not Available
	Spanish-American	2203	Welfare Recipients	295		
	Youth 16-21	6608	Veterans	1130		
	Older Workers	2203	Heads of Household	900		
			Youth	510		

Source: [a] Title I—Jackson Manpower Consortium, *CETA Program Planning Summary, Oct. 1, 1976, to Sept. 30, 1977;* Title II—Jackson Manpower Consortium, *CETA Program Planning Summary, July 1, 1974, to September 30, 1977,* Title VI—Jackson Manpower Consortium, *CETA Program Planning Summary, January 15 to September 30, 1977.*

[b] Alamo Manpower Consortium, *CETA Title I, Title II, and Title VI Program Status Summary, October 1, 1976, to March 31, 1977.*

[c] King-Snohomish Manpower Consortium, *CETA Title I Program Status Summary, July 1, 1975, to September 30, 1976.*

[d] State of Maine, Office of the Governor, *CETA Title I and Title II Program Planning Summary, October 1, 1976, to September 30, 1977.*

[e] Mayor's Office, City of St. Louis, *CETA Title I and Title II Program Planning Summary, October 1, 1976, to September 30, 1977.*

[f] City of Chicago, Mayor's Office of Manpower, *CETA Title I and Title II Program Status Summary, January 1, 1977, to March 31, 1977.*

school dropouts, young blacks, and females—in part because skills centers and community colleges that provide training are focused on younger persons.[125] Data for this site showed that 53.7 percent of Title I enrollees were under 22 and that 32 percent were under 19.

William Haltigan, Administrator of the Employment and Training Administration of the Department of Labor in San Francisco, testified:

> . . .[in] Title I, on the national basis, [there] is a preponderance of people served who are really very young people under the age of 20. . . .
>
> I think that what this reflects is that in Title I. . .decisions have been made by prime sponsors that a most significant need in their areas is to provide some sort of training or work experience for young people, ergo, the concentration of the clientele in the 20 and under group.[126]

Richard Lower, with the CETA balance-of-State program in California, stated:

> . . .people tend to drift more into things like public service employment where there is not quite as much traditional discrimination. A person does not assume that a 60-year-old man will belong in a classroom. . . .I call that traditional attitudes about the older people. . . .People of all ages tend to assume there is something wrong with a 60-year-old man being in classroom training. So, our data for the first six months of this fiscal year, which started in October, shows that in Title I, which is where we have our residual program interest in youth, we have 1.8 percent of the total served are over 55.[127]

Mr. Lower's balance-of-State program data were not unlike that reported for the San Francisco prime sponsor agency's Title I program. They showed that in the San Francisco program 45 percent of fiscal year 1976 Title I enrollees were under 22 and only 1.6 percent were 55 or over.

A program planner for Maine's balance-of-State program said that persons 55 or over are not considered in the planning for typical Title I programming. He added that training is not necessarily the approach to use with older workers—that public service employment is a better alternative.[128] Another member of the State staff said that it had been decided to place more emphasis on youth because youth are politically more visible and the structure of the Title I program lends itself to youth—work experience is not suited to persons 40 or over and on-the-job training is hard for people 18 to 24.[129] At this site, 38.6 percent of the Title I enrollees in fiscal 1976 were under 22, 4.8 percent were 45 to 54, and 2.4 percent were 55 or over.

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[125] Robert McPherson, director, King-Snohomish Manpower Consortium, interview in Seattle, Wash., Apr., 27, 1977 (hereafter cited as McPherson Interview).

[126] William Haltigan, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27-28, 1977, vol. I, p. 38 (hereafter cited as *San Francisco Hearing*).

[127] Richard Lower Testimony, *San Francisco Hearing*, p. 64.

[128] John Dorrer, CETA planner, Maine Balance-of-State CETA Program, interview in Augusta, Me., May 23-24, 1977 (hereafter cited as Dorrer Interview).

[129] Peter Thibodeau, program development and training coordinator, Maine Balance-of-State

The director of program development and administration for the King-Snohomish Manpower Consortium said that persons 14 and 15 are likely to participate in in-school programs; persons 16 and 17 are likely to be in work experience programs; and people 17 to 21 in vocational training. Persons of other ages, she said, have other expectations and needs. Although she did not elaborate on what these expectations and needs might be, she also gave no indication that the prime sponsor had attempted to address them through the training program.[130]

Orientation to youth was also shown by the way in which programs were operated. For example, at one site, Commission staff noted that the training facility had hall monitors and that written passes were required for program applicants to move about the building.[131]

The Department of Labor, in commenting on this aspect of the Commission's findings, stated that the inference that older persons are discriminated against in training programs may be accurate but that the Commission presented no documentation to show that older workers need or desire to participate in training programs to a greater extent than they do now.[132] The Commission had attempted to locate information on the extent to which different age groups need training and whether different participation rates should be expected for different age groups as a result. However, staff determined that little information is available on the subject in general. Department of Labor staff, in fact, reported to Commission staff that neither the Department nor the National Commission on Manpower Policy has conducted directly or through contract any research by age on who needs training or on the varying training needs of different age groups.[133] This lack of information was also noted by Secretary of Labor Ray Marshall when he told the Commission:

> . . .present available findings, data, and beliefs are inadequate for a complete understanding of the problems of the older worker and do not provide an adequate base upon which to determine the effectiveness and impact of federally-assisted programs on these workers.
>
> . . .To obtain new knowledge and analytical findings useful to the formation of future plans and recommendations for improving services to older workers, the Employment and

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CETA Program, interview in Augusta, Me., May 23-24, 1977 (hereafter cited as Thibodeau Interview).

[130] Jean Hoerschelman, director, Program Development and Administration, King-Snohomish Manpower Consortium, interview in Seattle, Wash., Apr., 27, 1977 (hereafter cited as Hoerschelman Interview).

[131] Alfrieda James, center manager, CETA Service Center, interview in San Antonio, Tex., Apr., 28, 1977 (hereafter cited as James Interview).

[132] Donald Elisburg, Assistant Secretary for Employment Standards, U.S. Department of Labor, memorandum to Sherry Hiemstra, Feb. 21, 1978.

[133] Margaret Fishman, manpower development specialist, Division of National Training Programs, Office of National Programs, Employment and Training Administration, U.S. Department of Labor, telephone interview in Wash., D.C. June, 1978.

> Training Administration has contracted with the American Institute of Research to prepare a research and development strategy concentrating on the employment-related problems of older workers.[134]

The contract to which Secretary Marshall makes reference has produced a report that identifies training as an area where additional research is indeed necessary. Entitled *Final Report: Research and Development Strategy on Employment-Related Problems of Older Workers*, the report cites several studies that have shown training to be effective for older workers, that older men tend to complete their training programs more often than younger trainees, and that training of older workers results in a lower dependency on social welfare payments than nontrainees of the same age.[135] The report concludes that these studies "suggest the value of a greater Departmental program emphasis on the training and retraining of underemployed older workers (or jobseekers)—accompanied, if necessary, by appropriate evaluations."[136]

The report also states that "older workers tend to be less interested than younger ones in learning new skills, or in participating in job training programs to obtain a different kind of job." It states, however, that this fact "should not detract from the further fact that substantial portions of these adult and older persons nevertheless are interested in training." To support this point, the report quotes figures from a 1974 Harris Survey in which nearly half of the employed 40- to 54-year-olds in the survey, 37 percent of those 55 to 64, and 21 percent of those 65 to 69 expressed an interest in learning new skills or participating in job training programs to obtain different kinds of jobs.[137] The report quotes the conclusion of the Harris Survey:

> There is apparently a serious need in this country today for career planning and job training programs for people of all ages. . .government and the private sector have until now aimed their job training efforts where the demand is greatest: among young people in their 20's and 30's. What this study reveals, however, is a substantial demand for similar programs by people in their 40's, 50's and 60's.[138]

This position was supported by Laurie Shields, national coordinator of the Alliance for Displaced Homemakers, who told the Commission:

> We know that there are approximately 3.3 million women right now in the country who fit the definition [of displaced homemaker]; we know there's a potential of 15 million more.
>
> . . .These people are not job ready. . .nor do they know where to seek the programs that do exist, presumably, to help them. . . .

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[134] Marshall Testimony, *Washington, D.C. Hearing*, p. 60.

[135] Harold L. Sheppard, *Final Report: Research and Demonstration Strategy on Employment-Related Problems of Older Workers* (Washington, D.C.: American Institute for Research, 1978), pp. 185–86.

[136] Ibid., p. 186.

[137] Ibid.

[138] Ibid.

> . . .But even if they do know, they are not job ready because both society and their own feeling has conditioned them to believe that their work. . .is bound by the home and therefore out in the world is something else. They don't think their skills are transferable; society tells them they are not.[139]

Despite the relative lack of information on the magnitude of need for training by older workers, it seems clear that there are older workers who need and would benefit from training opportunities. Indeed, without evidence to the contrary, it seems entirely reasonable to assume that older workers in a society with continously changing technological requirements and demands have needs for training on a par with other age groups.

As stated earlier, the Commission found that in the Titles II and VI programs, prime sponsors concentrated on enrolling persons between the ages of 22 and 44, because, they said, persons in this age group are considered to be within the "prime working age" range and regarded as "employable."

National data on Title II and Title VI show that in fiscal year 1976, 64 percent of the enrollees in each of the two programs were in the 22 to 44 age category. State and local program administrators uniformly conceded that their Title II and Title VI public service employment programs were concentrated on this age group. They attributed the high levels of enrollment in the programs to the fact that highest priority is placed on "primary working age" individuals.

Armando Quiroz, director of the Governor of Colorado's Special CETA Grant Program, said that the concentration on those between 22 and 44 was characteristic of the CETA programs in Denver and the State. He said further that administrators focus on "employable" persons, meaning those that "industry will pick up on" and "put to work once the recession fades." He added that these were persons between the ages of 22 and 44, not older workers. According to Mr. Quiroz, youth, too, face similar problems.[140]

William Haltigan, in the Department of Labor's San Francisco Office, testified:

> . . .in terms of [enrollment in] Titles II and VI, of that proportion for the very young, it drops to something less than 20 percent, with the biggest group being in the age group from about 20 to 44 and then dropping off quite substantially in the older ages.

> In the Titles II and VI. . .I think it's basically a reflection of the economic downturn we've had in the years since 1975 where the preponderance of people unemployed are really *in the prime working age so to speak, 20 through 44.* [141] [emphasis added]

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[139] Laurie Shields Testimony, *San Francisco Hearing*, pp. 25–26.

[140] Armando Quiroz, testimony, *Hearing Before the U.S. Commission on Civil Rights, Denver Colorado*, July 28–29, 1977, vol. I, p. 196–97 (hereafter cited as *Denver Hearing*).

[141] Haltigan Testimony, *San Francisco Hearing*, p. 38.

Eunice Elton, director of the Mayor's Office of Employment and Training in San Francisco, told the Commission:

> The majority of Title II and VI participants are certainly in the 22 to 44 age group. There is a smaller number in the 22 to 25, probably. The big lump is in the middle years, the head of household, and this is probably the result of our giving priority to heads of households.[142]

She added that other factors contributed to the bulk of program enrollees being aged 22 to 44:

> . . .Taking just the Title II and VI programs, we have a priority for veterans, a very strong push for service to Vietnam-era veterans. While my contemporaries of the World War II period come from the older worker category, the Vietnam-era veterans substantially do not. They are the young persons in the 25 to 44 range. That has an impact. In addition, the priorities that we attempt to give people in the program of aid to families with dependent children automatically throws them into the middle age range. In the Title I program 20 percent of our participants are in AFDC families. They will necessarily be persons who are dependents or the head of households who is in the middle years.[143]

Data for San Francisco show that 80.4 percent and 80.3 percent of the fiscal year 1976 enrollees in the Title II and Title VI programs, respectively, are between 22 and 44.

Thus, because prime sponsors narrowly interpret training to be for persons under 22 and public service employment to be for persons 22 to 44 whom they consider "employable," potential and actual enrollees are limited because of their age in the types of assistance they can receive or expect to receive, and some age groups are not perceived as fitting into either category.

Performance Standards

The Title I, Title II, and Title IV programs under the Comprehensive Employment and Training Act all emphasize the importance of placing individuals in employment not subsidized under the act, and programs are evaluated in part on their success in meeting this goal.

Federal regulations for Title I provide that program activities should be primarily directed toward the placement of individuals in unsubsidized employment, either directly as a result of intake and assessment or indirectly through the provision of training or services.[144] The Title I comprehensive manpower plan submitted by each prime sponsor must set forth performance goals for its program.[145] With regard to these performance goals, Federal regulations provide that the plan must include a statement of the specific client, training, and occupational goals and objectives the prime sponsor intends to accomplish and a discussion of the planned placement goals as well as a description of the placement and followup mechanisms and procedures to be used.[146]

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[142] Eunice Elton Testimony, *San Francisco Hearing*, p. 56.

[143] Ibid., pp. 56–57.

[144] 29 C.F.R. §95.33(a) (1976) (effective July 26, 1976).

[145] 29 U.S.C. §815(a)(1)(A) (Supp. V 1975). See also 29 C.F.R. §95.14 (1976) (effective July 26, 1976) for the specific parts of the plan in which prime sponsors must relate their occupational goals,, placement goals and the like.

Title I prime sponsor applicants, as part of their plans, must submit specific information on the number of persons they plan to enroll in the programs, the total number of terminations they expect, and, within that category, the total who are expected to enter employment (broken out by direct and indirect placements), other positive terminations (that is, persons leaving the program to enter full-time academic or vocational schools, the Armed Forces, or enroll in a program supported under another CETA title or a manpower program not supported under CETA), and nonpositive terminations.[147]

In reviewing grant applications for Title I, one factor a Regional Administrator must consider is whether the performance goals in the application, including those for placement, are reasonable in light of past program experience in the same or similar activities and the documentation provided by the prime sponsor.[148]

Once an application is funded, the prime sponsor, on a quarterly basis, must submit information on the actual number of enrollments and terminations, including the total number of individuals placed in unsubsidized employment at termination from the project, together with the same information as it was estimated in the plan.[149] This information is then used in a formal performance assessment conducted by the appropriate regional office, which has been the basis for designating prime sponsors for the next fiscal year.[150] The performance criteria used in fiscal year 1976 involved review of six areas of program performance, which included the administrative cost rate, accrued expenditures in the various types of training, enrollment in the various types of training, the total number of persons entering employment, the entered employment rate, and the nonpositive termination rate. Specific targets for these areas were not set; regional officials were to identify any significant deviation (less than 15 percent) from the planned performance goals.[151]

The Title II and VI programs also emphasize placement of individuals in unsubsidized employment. The act provides that financial assistance under Title II and Title VI is for the purpose of providing transitional employment for unemployed and underemployed persons in jobs providing needed public services and, where feasible, training and manpower services to enable such persons to move into employment or training not financed under the act.

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[146] 29 C.F.R. §95.14(b)(2)(i)(B) (1976) (effective July 26, 1976).

[147] U.S., Department of Labor, *Forms Preparation Handbook*.

[148] 29 C.F.R. §95.17(b)(4) (1976) (effective July 26, 1976).

[149] 29 C.F.R. §98.8(a).

[150] U.S., Department of Labor, Employment and Training Administration, *Field Memorandum No. 224-76: Formal Performance Assessment of Prime Sponsors for Funding FY 1977 CETA Grants*, Jan. 30, 1976. On May 8, 1978, the Department of Labor confirmed formally that these performance ratings for Title I, II, and VI are used as the basis for determining whether a prime sponsor receives its funding for the next fiscal year. A press release announced that "ratings derived from the assessments will determine whether a prime sponsor receives its full fiscal year allocation of funds on October 1, when the year begins."

[151] Ibid.

The act authorizes the Secretary of Labor to establish placement goals for Title II and Title VI prime sponsors but cautions that the Secretary may not impose such goals as requirements.[152] Federal regulations require that for Titles II and VI, each prime sponsor, program agent, or subgrantee shall have the goal of accomplishing each year at least one of the following:

- placing half of the cumulative participants in unsubsidized private or public sector employment

- placing participants in half the vacancies occurring in suitable occupations in a [prime sponsor], program agent, or subgrantee's permanent work force which are not filled by promotion from within the agency.[153]

If a prime sponsor believes the established goals are not feasible, he may request a waiver from the Regional Administrator.[154] If a waiver has been granted, failure to meet the placement goals may not be cited in any official review or evaluation of the prime sponsor's program.[155]

Despite these qualifications on the issuance and enforcement of placement goals, the Commission found that prime sponsors for Titles I, II, and VI programs have considered the goals to be requirements, and as a result, some age groups considered more difficult to place in unsubsidized employment have been screened out of the program in order to ensure a high placement rate.

Arthur Douglas of the Department of Labor's Regional Office in San Francisco described the effect of placement requirements on the composition of persons accepted into CETA program:

> . . .the Labor Department does put out not absolute requirements but guidelines about percentages of people that enter that program that we would like to see end up in nonsubsidized jobs. That's, as we understand it, the intent of Congress in passing the legislation; that Title I is to be a training program and the payoff is to be placement into a job. . . .[T]here is the emphasis on our part basically to keep costs down and to get placements up, because that is what we believe the program is. . . .[T]here's no reason for any overt discrimination, but what could impact on it, of

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[152] 29 U.S.C. §§815(b), 962(c) (Supp. V 1975).

[153] 29 C.F.R. §96.33(c)(1)-(2) (1976) (effective July 26, 1976). See also 42 Fed. Reg. 2426, 2434 (1977) (to be codified in 29 C.F.R. §99.36). The provision does not apply, however, to new projects or activities funded under Title VI.

[154] 29 U.S.C. §§815(b), 962(c) (Supp. V 1975); 29 C.F.R. §96.33(e)-(f) (1976) (effective July 26, 1976); 42 Fed. Reg. 2426, 2434 (1977) (to be codified in 29 C.F.R. §99.36).

[155] 29 U.S.C. §§851(b), 962(c) (Supp. V 1975).

> course, is the labor market itself, the kind of jobs available, the need to take into the program those whom they believe with good training they can put out into jobs. That's a decision the prime makes.[156]

Asked whether the prime sponsor, in order to achieve a "reasonable or seemingly effective" placement rate, would usually accept a younger worker in the belief that an employer will more readily hire a younger person than an older worker, Mr. Douglas said:

> I don't think that any primes ever told me that they consciously make that decision. But, you know, it seems to me if you look at data of people served, as Mr. Haltigan has testified earlier and the staff has pointed out, that the preponderance of people are younger people.[157]

Commission staff were told further that in the Title I program, prime sponsors in some sites, to assure that they meet their placement goals, have required subcontractors to place a specified portion of the persons they train. To meet this requirement, the subcontractors have, in turn, selected as enrollees those persons who are easier to place.[158] Among the persons identified as harder to place in employment or other training were persons 45 or over.[159] The effect of this "creaming" to meet placement requirements is suggested by data for three sites where placement requirements were included in contracts—San Francisco, Seattle, Chicago.

In San Francisco, for example, the prime sponsor had established specific placement objectives for each subcontract awarded for Title I activities. The plan for fiscal year 1977 stated that subcontracts would be designed to achieve the number of placements for which contracts were awarded and that the program and activities for which contracts would be awarded were simply "the means to the end," namely, placement. The plan established the objective of a 70 percent minimum placement rate for most subcontractors.[160] Data on the age distribution of enrollees in Title I at this site show a low percentage of enrollees 45 or over—2.7 percent, 45 to 54; 1.2 percent, 55 to 64; and 0.4 percent, 65 or over. This is one of the lowest percentage distributions of persons 45 or over in any of the nine sites visited.

In Seattle, Commission staff were told that agencies providing training under the Title I program were given responsibility for placing the individuals they trained. If individuals were not placed, the agencies' contracts would not be renewed.[161] As a result of this requirement, agencies providing training had a great incentive to select persons who could be placed fairly easily. Commission staff were also told that persons 45 or over were harder to place in unsubsidized employment then other age groups, and consequently prime sponsors "creamed" clients who were easier to place for enrollment in their programs;[162] that is, choosing applicants who are job-ready and easier to place in unsubsidized employment, or, in other words, screening out those persons in need of services who may face serious employment barriers. At this site, too, data showed few enrollees 45 or over—-2.7 percent were 45 to 54, 0.6 percent were 55 to 64, and none were 65 or over.

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[156] Arthur Douglas Testimony, *San Francisco Hearing*, p. 45.
[157] Ibid., p. 46.
[158] Cletus Lynch, area director, Washington State Employment Service, interview in Seattle, Wash., Apr. 29, 1977 (hereafter cited as Lynch Interview).
[159] Ibid.
[160] City and County of San Francisco, Office of the Mayor, *Application Abstract for CETA Title I, 1976*, p. 4.
[161] Lynch Interview.

Commission staff were told in Chicago that applicants had been accepted previously into the Title I program on a first-come, first-served basis. Beginning with fiscal year 1977, the agency decided to serve, as its first priority, persons with the most potential for getting and keeping a job. Although adoption of this "creaming" policy was fought by some prime sponsor staff, the director said that once it was adopted, it became clear that "contractors who had been successful in terms of placements had always been creaming and this policy just took it out of the closet." He said that this policy probably did not affect the age distribution of participants, because it is done within various demographic categories and that the policy merely affirmed common practice.[163] Fiscal year 1976 data on Title I enrollees, however, show that all age groups were *not* equally affected: only 11.6 percent of the Title I enrollees in Chicago were under 19 and only 7 percent were 45 or over.

In announcing the availability of Title I funds for fiscal year 1976, the Mayor's Office of Manpower in Chicago issued a notice that subcontractors would be required to meet these placement goals in order to receive funds:

> There is a long waiting list of agencies who wish to apply, thus only those who meet the target of transitioning at least half the workers hired to permanent jobs will be considered for refunding.[164]

The distribution of persons 45 or over in the Chicago Title I program was 7 percent: 3 percent of enrollees were 45 to 54, 1.6 percent were 55 to 64, and 2.4 percent were 65 or over. The relatively higher percentage of persons 65 or over in this program may result from a special older worker program set up by the city under which 500 part-time jobs were created for workers 62 and over.[165]

The fact that older persons are considered harder to place and that this influences placement goals for Title I programs and enrollment in those programs was further demonstrated in Jackson, Mississippi. For fiscal year 1977, the Title I CETA plan for Jackson established, as program goals, specific placement rates for each type of activity supported under its Title I program. Placement rates of 50 percent or more were established for adult basic education, on-the-job training for high school dropouts, classroom training, and on-the-job training. However, a placement rate of 15 percent was set for a work experience program for older persons. This low placement rate was expected, the plan said, "due to age handicaps." Thus, the agency had decided that older persons would possibly be more difficult to place and had dealt with this possibility by isolating older persons in a separate, part-time, work experience program. It seemed likely that subcontractors would be reluctant to bring older persons into the other programs, which had much higher placements rates, when those individuals were recognized as difficult to place.[166]

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[162] Ibid.

[163] David Cohen, director of program development, Mayor's Office of Manpower, interview in Chicago, Ill., May 16, 1977 (hereafter cited as Cohen Interview).

[164] City of Chicago, Mayor's Office of Manpower, *Report:* "Planning Council Expands Training and Employment Programs," vol. 2, no. 2 (1976), p. 2.

[165] Ibid.

The plan noted that recruitment and preselection of trainees would be performed by each contractor or subcontractor and that the employment service, which was responsible for all placements, would certify screened applicants as eligible. It stated further that "target groups are found in each contractor's plan and each contractor will attempt to meet these goals," and "maximum efforts will be made, including redesign of program components and/or elimination of contractors if necessary, to meet grant goals."[167] Although specific information was not available to determine whether subcontractors were, in fact, reluctant to enroll older persons in programs, other than the work experience program, data for the site show a very low percentage of enrollees 45 or over—2.5 percent were 45 to 54; 1.7 percent, 55 to 64; and 0.8 percent, 65 or over.

In fulfilling the placement goals, prime sponsors are dependent on private and public employers, who in their hiring may discriminate against certain persons on the basis of their age. (This is discussed in greater detail later in the chapter.) Consequently, prime sponsors target their programs toward those age groups that private and public employers are willing to hire. The data on Title II and Title VI, as stated earlier, show concentrations of enrollees in the 22 to 44 age range and in excess of their representation in the unemployed population.

It appears that some agencies try to take into account the reluctance of some employers to hire certain groups of persons; for example, the King County Public Employment program in Seattle, Washington, developed a numerical scoring system that rated agencies requesting funds on the basis of whether they committed themselves to absorb CETA participants into their own work force and the extent to which they had met commitments to place individuals in prior years. The county gave extra credit to applicants who agreed to attempt to hire persons from any of the following groups: poor people who are older workers, offenders, handicapped persons, minorities, youth, Vietnam veterans, public assistance recipients, or 15-week unemployment insurance recipients.[168]

The Secretary of Labor, in response to written questions submitted by the Commission, indicated that the Department is

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[166] Jackson, Mississippi, Manpower Consortium, *Title I CETA Plan for Fiscal Year 1977*, pp. 16–21.

[167] Ibid., p. 23.

[168] Judith Ball, Federal employment program administrator, King County Public Employment Program, interview in Seattle, Wash., Apr. 28, 1977 (hereafter cited as Ball Interview).

"aware that a 'creaming' problem does exist" and is "making an effort to eliminate it." He further stated that "prime sponsors should not feel a need to 'cream' in making participant selections in order to achieve a satisfactory evaluation."[169]

Program Administrators' Policies and Practices

As indicated earlier, under the Titles I, II, and VI programs, prime sponsors have fairly extensive discretion to choose what groups of the population they will emphasize and the types of training and jobs they will provide. Commission staff determined that prime sponsors make decisions in these areas that exclude or discourage some age groups from participating in their programs.

How prime sponsors determine what persons in the population are unemployed or would be potentially eligible for services influences who they serve and how they design their programs. In Maine, Commission staff found that the balance-of-State prime sponsor determined the number of unemployed persons in the eligible population by estimating the number of persons between the ages of 14 and 55. Persons over 55 were not included in the assessment, although older workers (45 or over) were 15 percent of job seekers in the area in fiscal year 1976. Neither the planner for the prime sponsor agency nor other staff members knew why the age 55 limit was used.[170] The effect of planning based on the unemployed population between 14 and 55 is suggested by the participant data for the site, which show that only 2.4 percent of Title I enrollees were 55 or over, and 4.9 and 3.8 percent of Titles II and VI enrollees, respectively, were 55 or over. (See table 4.10.) However, the data for Maine do not differ substantially from other areas that do not expressly exclude those over 54 in their planning. (See table 4.6.)

Commission staff learned in St. Louis that age 22 had been set as the general lower age cut-off for training at one of the skills centers with which the prime sponsor contracted. When asked the reason for the age limitation, the field services coordinator at the center replied that she had been told that "22 was based on research."[171] St. Louis had a higher percentage of Title I enrollees in the 22 to 44 age group than any of the other sites visited—57.6 percent (See table 4.6) Some other prime sponsors estimated the unemployed population by determining the number of persons between 16 and 64. Persons under 16 and 65 or over were not counted for purposes of planning and designing programs.[172]

At several points during the study, Commission staff were told that discrimination on the basis of age often results from the types of jobs and training that prime sponsors and their program agents elect to provide. With regard to public service employment, Title II and Title VI

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[169] Ray Marshall, Secretary of Labor, letter to Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, Nov. 15, 1977, question B. (hereafter cited as Marshall Letter).

[170] Dorrer Interview. See also Thibodeau Interview.

[171] Riola Interview.

[172] City of St. Louis, *Title I CETA Plan for Fiscal Year 1977*, pp. B-35 and C-3; State of Illinois, Governor's Office of Manpower and Human Development, *Title I CETA Plan for Fiscal Year 1977*, pp. 13-16.

Table 4.10
Percent Distribution of CETA Titles I, II, and VI Enrollees by Age, Maine Balance-of-State Program, Fiscal Year 1976

Age Group	Title I	Title II	Title VI
All Ages	100.0%	100.0%	100.0%
Under 19	9.9	0.8	0.7
19-21	28.7	12.5	10.7
22-44	54.3	67.2	70.6
45-54	4.8	11.1	9.8
55-64	2.1	7.0	6.7
65 +	0.3	1.4	1.5

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

require the prime sponsor to assure that not more than one-third of the participants in a program will be employed in a bona fide professional capacity, except in the case of classroom teachers or waivers of this limitation by the Secretary,[173] and that no job will be filled in other than an entry level position in each promotional line until compliance with applicable personnel procedures and collective bargaining agreements has been achieved.[174] Federal funding for public service jobs is limited to a full-time maximum rate of $10,000.[175]

The fact that most positions are entry-level positions was cited repeatedly to Commission staff as a reason why more older workers do not participate in the public employment programs. Martin Flahive, a senior policy analyst for the City and County of Denver, said that with few exceptions, public service employment positions were low status, dead-end, and/or heavy labor jobs and entry-level clerical jobs. He pointed out that these types of jobs

> . . .may deter a person who has worked a lifetime in responsible, meaningful, and reasonably prestigious endeavors from going to that work. . . .They offer little range of advancement to. . .responsible and well-paying work. . . .They entail in many cases considerable physical exertion.

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[173] 29 U.S.C. §§845(c)(22), 962(c) (Supp. V 1975).

[174] 29 U.S.C.A. §845(c)(24) (West Supp. 1977) and 29 U.S.C. §962(c) (Supp. V 1975).

[175] 29 U.S.C. §§848(a)(3), 962(c) (Supp. V 1975).

Mr. Flahive added that such jobs "are not. . .the kind that a person with meaningful work experience and perhaps the responsibility of a family can afford to or will chose to take."[176]

The types of jobs available at the field study sites supported Mr. Flahive's observation. Staff of two prime sponsor agencies said that most public service jobs in their areas were entry-level positions and, as a result, older persons did not apply. They also said that these positions frequently involved "strenuous physical activity" that limited the number of applications from older workers.[177]

The limited availability of part-time work was also raised as a possible deterrent to older applicants. The Comprehensive Employment and Training Act provides for part-time jobs for individuals who, because of age, handicap, or other factors would be unable to work full time.[178] Title VI, in providing public service jobs and determining hours of work for eligible persons, states that each prime sponsor shall take into account the household support obligations of the men and women applying for such jobs and shall give special consideration to such alternative working arrangements as flexible hours of work, shared time, and part-time jobs for eligible persons, particularly for parents of young children and for older persons.[179]

Commission staff found that part-time employment was available at only two of the six sites that were visited during the field study. In San Antonio, 40 slots were reported to be set aside for veterans attending school full time. All other positions were full time.[180] The director of public service employment in St. Louis stated that there was a demand among persons already retired for part-time work, but the city had made a decision that all public service employment positions would be full time. The reason for this decision, he said, was that the administrative costs of carrying two people part time exceeded the costs of carrying one person full time. He also said that there were fewer supervisory difficulties with full-time employees.[181]

The fact that public service employment positions at the sites that Commission staff visited were primarily full-time, entry-level positions indicates that prime sponsors did not tailor their programs to meet the needs of persons who, the act recognizes, may require the option of part-time employment—older persons, handicapped persons, and parents of young children, among others. It also indicates that even where a demand for part-time work was known, considerations other than meeting known employment needs determined the design of the program.

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[176] Martin Flahive Testimony, *Denver Hearing*, pp. 191–92.

[177] Edward Garcia, director, Emergency Employment Act Office, interview in San Antonio, Tex., Apr. 29, 1977 (hereafter cited as Garcia Interview); Kelly Interview.

[178] 29 U.S.C. §981(a)(7) (Supp. V 1975).

[179] 29 U.S.C.A. §968(d) (West Supp. 1977).

[180] Garcia Interview.

[181] Kelly Interview.

Historical Patterns

Title I of the Comprehensive Employment and Training Act requires that a prime sponsor's comprehensive manpower plan:

> . . .provide(s) for utilizing those services and facilities which are available. . .to the extent deemed appropriate by the prime sponsor, after giving due consideration to the effectiveness of such existing services and facilities, including but not limited to, the State employment service, State vocational education and vocational rehabilitation agencies, area skills centers, local educational agencies, postsecondary training and education institutions, and community action agencies. . . .[182]

These are the types of agencies that operated training programs under the Manpower Development and Training Act (MDTA)[183] and the Economic Opportunity Act.[184] These acts, before they were placed under CETA, funded the Neighborhood Youth Corps, the Job Corps, and a work experience program for recipients of AFDC and other needy persons.[185] Community-based organizations were also funded under MDTA and the Neighborhood Youth Corps.[186] These included the Urban League, Opportunities Industrialization Centers (OIC), and Operation Service, Employment, Redevelopment (SER).[187]

The institutional training activities for MDTA programs were operated in skills centers or in public or private schools. On-the-job training was operated by unions, companies, trade associations, and other public agencies.[188] Neighborhood Youth Corps programs, which supported training and employment for in-school youth under 21 and out-of-school youth 16 to 18, were operated by public schools (35.3 percent of the projects), community action agencies (34.9 percent of the projects), and private, nonprofit organizations (9.1 percent of the projects).[189]

Both programs placed extensive emphasis on youth training. According to a review of Federal manpower and work training programs, the MDTA programs "concentrated at first on the needs of unemployed family heads with a past history of labor force attachment. . .[but] shifted to youth."[190] A 1966 study of selected skills centers funded under MDTA showed that over 40 percent of the participants were under 22 and only 9 percent were over 44.[191] In addition, a Department of Labor analysis of all of its programs operating in 1972 showed that "almost 70 percent of all enrollees were under 22 years of age."[192]

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[182] 29 U.S.C. §815(a)(3)(B) (Supp. V 1975).

[183] Manpower Development and Training Act of 1962, Pub. L. No. 87-415, 76 Stat. 23 [codified in scattered sections of 42 U.S.C. (1970)].

[184] Economic Opportunity of 1964, Pub. L. No. 88-452, 78 Stat. 508 [codified in scattered sections of 42 U.S.C. (1970)].

[185] Sar A. Levitan and Robert Taggart III, *Social Experimentation and Manpower Policy: The Rhetoric and the Reality* (Baltimore: The Johns Hopkins Press, 1971), pp. 108-11 (hereafter cited as *Social Experimentation*).

[186] Sar A. Levitan and Joyce K. Zickler, *The Quest for a Federal Manpower Partnership* (Cambridge: Harvard University Press, 1974), p. 32.

[187] *Employment and Training Report, 1976,* p. 98.

[188] Levitan and Taggart, *Social Experimentation,* pp. 108-11.

[189] Sar A. Levitan, *Antipoverty Work and Training Efforts: Goals and Reality* (Ann Arbor: Institute of Labor and Industrial Relations, 1967), pp. 46, 49.

[190] Sar A. Levitan and Garth L. Mangum, *Federal Training and Work Programs in the Sixties* (Ann Arbor: Institute of Labor and Industrial Relations, 1969), pp. 10-12.

The Department of Labor reported that during the first year of the CETA program, prime sponsors "made few major changes from the groups that had previously supplied these services under categorical programs. . . .By and large. . .the sponsors decided to renew ongoing contracts with existing operators of major components such as classroom training and work experience."[193]

This is supported by information obtained during the field study. At two of the six sites that Commission staff visited, skills centers were the predominant delivery agent for Title I services.[194] Among the major providers of services at other sites were community action agencies, public schools, and OIC and SER.[195]

The effect of this continued support of agencies that operated programs under the earlier manpower programs is suggested by a statement made by the director of program development and administration for the King-Snohomish Manpower Consortium that had contracted its Title I program with agencies already providing manpower services when CETA was enacted. Asked whether this decision had restricted the age groups of persons who could be served, she said that most of the training programs had been oriented to persons aged 18 to the early 20s.[196]

Data available on participation in the Title I program also suggest that these agencies, which are frequently the agencies responsible for recruiting individuals to their programs, are continuing to serve the same clientele. The Department of Labor reports that "Fiscal 1976 Title I programs in general have continued to serve persons with characteristics quite similar to those of enrollees in pre-CETA categorical programs."[197] Of Title I enrollees in fiscal year 1974, 63 percent were under 22, compared to 61.7 percent in fiscal year 1975 and 56.7 percent in 1976. Of the Title I enrollees in 1974, 6.2 percent were 45 or over, compared to 6.1 percent in 1975 and 6.8 percent in 1976.[198]

Outreach and Referral Activities

Under Secretary of Labor Robert J. Brown said in April 1977:

> CETA provides the means to offer older men and women valuable job training or retraining, as well as

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[191] Ibid., p. 68.

[192] U.S., Department of Labor, *Manpower Report of the President* (1973), p. 54.

[193] *Employment and Training Report, 1976*, p. 97.

[194] Mary Canada, assistant director, St. Louis Agency on Training and Employment, Arthur Kennedy Skills Center, interview in St. Louis, Mo., Apr. 6, 1977, (hereafter cited as Canada Interview); James Interview.

[195] Jackson, Mississippi, Manpower Consortium, *Title I CETA Plan for Fiscal Year 1977*, pp. 24–25, 27; *Maine Balance-of-State CETA Plan for Title I for Fiscal Year 1977;* King-Snohomish Manpower Consortium, *Listing of Title I Program Agents; California Balance-of-State CETA Plan for Title I*, pp. 21–25; Sam Dominquez, director of Manpower, interview in San Antonio, Tex., Apr. 27, 1977 (hereafter cited as Dominquez Interview).

[196] Hoerschelmann Interview.

[197] *Employment and Training Report, 1977*, p. 46.

[198] Ibid., p. 47.

> public service employment. But part of the problem stems from the fact that many older persons no longer consider themselves part of the labor force—and many do not seek jobs simply because they assume they will not be hired. That means strong outreach efforts are required of prime sponsors to assure that older people are aware of CETA services and that these individuals are encouraged to participate.[199]

His statement suggests that outreach for CETA programs is valuable and that outreach to older persons by prime sponsors would be necessary to ensure that they have an opportunity to participate in CETA programs; however, in the sites included in the age discrimination study, the Commission found little evidence of any general outreach and less outreach for older persons.

In four of the six sites that Commission staff visited as part of the field study, the principal mechanism for informing unemployed and underemployed persons about training and public service employment opportunities was the State employment service.[200] The employment service also acts as the intake point for the training and public service employment program, accepting applications for CETA training or public service employment, screening individuals to determine whether they are eligible to participate in the program, and, in some cases, working with employers to find unsubsidized employment for CETA enrollees.[201] In all of these areas, it appeared that the employment service offices were doing little, if any, active outreach to inform individuals about the availability of CETA training and public service employment programs.

CETA staff interviewed at two sites said that little or no outreach for available positions is conducted by the employment service agencies in their areas. The area director for the Washington State Employment Service in Seattle, who had just been given responsibility for an outreach program, said the staff wait for people to come to them, rather than going out to the community to provide information. He said that outreach is done on a selective basis—when an employer has requested someone for a job and applicants on file are not qualified for the job. He also said that the need for training so far outdistances training resources that advertising is almost a disservice, and he would be more inclined to focus outreach on persons who would fit the qualifications for available jobs.[202]

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[199] U.S., Department of Labor, Office of Information, *NEWS*, "Speech Prepared for Delivery by Robert J. Brown, Under Secretary of Labor, Before the 27th Annual Conference of the National Council on Aging," Apr. 20, 1977, p. 4.

[200] The U.S. Employment Service, authorized by the Wagner-Peyser Act, June 6, 1933, ch. 49, 48 Stat. 113 [codified at 29 U.S.C. §49 (1970)], supports grants to State employment service agencies for the establishment of a Federal-State system of local employment offices intended to serve as a labor exchange between public and private employers and potential employees. In addition to matching persons looking for work with employers' requests for individuals to fill available positions, the employment service also administers the work test requirement for unemployment benefits, food stamps, and aid to families with dependent children, provides labor market information, and provides assistance to groups, such as veterans, who have been identified as particularly disadvantaged in the job market. U.S., Department of Labor, Employment and Training Administration, *The Employment Service: An Institutional Analysis* (Washington, D.C.: Government Printing Office, 1977), p. ix.

[201] Dominquez Interview; Kelly Interview; Ball Interview; Jackson, Mississippi, Manpower Consortium, *Title I CETA Plan for Fiscal Year 1977*, pp. 23, 24.

According to a staff member of the prime sponsor agency at the second site, the employment service provides outreach only for veterans, and no application is accepted unless a position is available in a training or public employment program.[203] Another staff member at this site said the employment service had advertised Title I training programs with schools and guidance counselors, but this had been stopped because of the cost.[204]

The Commission also received testimony on this limited outreach by the employment service. James Nicholson, chief of the Employment Services Section of the California Employment Development Department, testified:

> The department currently, at last blush, had one and a half million applicants on file, applicants available for services, and that's housed in some 123 offices throughout the State. Of that figure, some 334,000 are 45 years of age and older and 350,000 are under 21. And so our need for outreach in the traditional sense of the word would only be performed on a selected basis.[205]

That older workers receive limited services from the State employment service has long been recognized as a problem. The Department stated in its response to questions submitted by the Commission that "there has been some erosion in the number of older worker specialists due to turnover and the demands of new programs."[206] The Secretary of Labor testified:

> The Employment Services has a mandate to provide a complete program of intensive counseling, assessment, job development, placement, and training and social services to meet the employment-related needs of middle-aged and older workers with the use of staff specially trained to recognize and to cope with age-related employment problems. However, the facts and statistics indicate that the results may not be adequate.
>
> The statistics show that the older workers are not being placed in the same proportion as other job applicants.[207]

These data are shown in table 4.11.

Part of this low rate of placement of older workers through the employment service may reflect discrimination against older workers in the private employment sector, as is discussed elsewhere in this report. The fact that older persons are, or are considered, more difficult to place, however, may result in less interest in serving them by the staff of the employment service. As reported in a recent research monograph on the employment

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[202] Lynch Interview.

[203] Tim McLellan, director of planning and evaluation, Kennebec County CETA, interview in Augusta, Me., May 25, 1977.

[204] Thibodeau Interview.

[205] James Nicholson Testimony, San Francisco Hearing, p. 69.

[206] Marshall Letter, question D–1.

[207] Marshall Testimony, *Washington, D.C. Hearing*, p. 62.

Table 4.11
Members of Employment Service Target Groups Who Received Reportable Services, All Sources of Funding, Fiscal 1976
(Percent[a] distribution)

Selected services[b]	Total number[c] (thousands)	Veterans	Migrants[d]	Women	Minority members	Economically disadvantaged workers	Handicapped workers	Older workers (45 and older)	Youth (under 22)
Counseled	877	21.5	0.3	46.4	35.7	51.9	14.9	11.1	32.4
Tested	679	11.8	.2	63.9	31.2	28.0	7.3	6.2	43.0
Enrolled in training	192	13.5	.3	52.3	42.6	67.7	6.8	4.9	44.6
Received job development	1,078	27.5	.5	39.7	34.2	32.8	8.1	13.2	27.5
Placed:									
In all jobs	3,367	17.8	1.3	41.5	30.8	31.9	5.1	10.2	41.4
In nonagricultural industries	3,200	18.1	.4	42.4	30.5	31.5	5.2	10.0	41.2

[a] Percentages are based on the total new and renewal applications filed in local emplyoment service offices from July 1, 1975, through June 30, 1976. Not included are those applications made earlier than July 1 that were still active during fiscal 1976. Because the same individual may be a member of more than one target group, the sum of percentages for a selected service will equal more than 100.

[b] Services reported under the Employment Security Automated Reporting System (ESARS).

[c] Figures are for all new and renewal applicants. Because the same individual may receive more than one service, the figures in this column add to a greater number than total applicants.

[d] Does not include nonmigrant seasonal farmworkers. Percentages represent only those farmworkers and food processing workers whose experience during the preceding 12 months required travel such that the worker was unable to return to his/her residence (domicile) in the same day.

Source: U.S., Department of Labor, and U.S. Department of Health, Education, and Welfare, *Employment and Training Report of the President* (1977), p. 76.

service developed for the Department of Labor by the Urban Institute:

> . . .placement productivity is the dominant factor affecting state funding allocations under the USES'S Resource Allocation Formula (RAF). USES guidance to State agencies also emphasizes mainstream placement as the ES's primary mission.[208]

In other words, an agency's funding is in large part based on its success in placing persons in employment; therefore, there might be a tendency for ES staff to seek out easier-to-place rather than harder-to-place persons.

Few ES staff were interviewed as part of the age discrimination study, so it was not possible to corroborate whether this is the case. However, Barbara Dudley, an attorney with the Senior Citizens Law Program of the California Rural Legal Assistance Program, stated in testimony before the Commission that this was the case:

> Employment services are 100 percent federally financed. And because of that, the formula for reimbursement that the Department of Labor sets up encourages the local departments, the EDD, to serve only the easily placed, the readily placed, the job ready, whatever you want to call them, and one of the problems with older work-

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[208] U.S., Department of Labor, Employment and Training Administration, *The Employment Service: An Institutional Analysis*, R & D Monograph 51, prepared by The Urban Institute (1977), p. 3. See also, *Employment and Training Report*, 1977, p. 75.

> ers is they are not necessarily the job ready and they are not among the easiest to place in this current employment market.[209]

Even where employment service agencies are not solely responsible for outreach under the CETA program, there was little evidence of outreach being conducted. In Maine, outreach efforts, other than those for which the employment service was responsible, were referred to as "recruitment efforts" and were, according to the Title I balance-of-State plan, the responsibility of the individual subcontractors.[210] The plan of one of these subcontractors, however, states with respect to "recruitment":

> The need for recruitment will probably remain minimal due to higher unemployment rates. However, in order that the greatest number of unemployed and/or disadvantaged people are aware of CETA training, ACTP [the local subcontractors] will direct outreach to communities in the following manner:
>
> 1. Distributing printed materials and keeping open communication with schools, employment service, social service agencies, probation and parole offices, town and city governments, and other community agencies.
>
> 2. Working closely with MESC (the Maine Employment Services Council) to keep them aware of openings in the program.
>
> 3. Relying on word-of-mouth communication.
>
> 4. Using media periodically for advertisements.[211]

Thus, outreach was minimal and no special target groups for outreach, including older persons, were identified.

Reliance on Public and Private Employers

Selection of individuals for positions under the Title II and Title VI public service employment programs is made by program agents and other agencies that have contracts or other agreements with prime sponsors.[212] These agencies may select from among several applicants for CETA positions, the individual who meets their requirements and whom they are willing to hire. The agencies become responsible for trying to place these persons in unsubsidized employment, either in their own work force or in the unsubsidized work force of other agencies and organizations.[213]

Because these agencies can choose to hire CETA workers from among many individuals who apply for public service employment positions, whether they discriminate on the basis of age in their hiring becomes critical. In addition, the extent of discrimination on the basis of age in the public and private employment sectors is important because agencies hiring CETA employees are concerned about being able to place them in unsubsidized employment.

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[209] Barbara Dudley Testimony, *San Francisco Hearing*, p. 15.

[210] Maine Balance-of-State, *Title I CETA Plan for Fiscal Year 1977*, p. 38.

[211] Androscoggin, Franklin, and Oxford Counties, Maine, *Regional Council Plan Digest* (1976), p. 138.

[212] 29 C.F.R. §96.25(a) (1976) (effective July 26, 1976); 42 Fed. Reg. 2426, 2436 (1977) (to be codified in 29 C.F.R. §99.42(c)(1)).

[213] 29 C.F.R. §96.33(b) (1976) (effective July 26, 1976); 42 Fed. Reg., 2426, 2434 (1977) (to be codified in 29 C.F.R. §99.36).

That public and private employers discriminate against individuals on the basis of their age has been well-recognized and documented. The existence of such discrimination resulted in enactment of the Age Discrimination in Employment Act of 1967, which prohibits most employers from discriminating against persons between 40 and 65.[214] Even with such legislation, however, age discrimination in employment continues to be a critical problem.[215]

The Department of Labor, in its 1976 report to the Congress on activities under the Age Discrimination in Employment Act, said with regard to persons between 40 and 65:

> During fiscal year 1976, 8,318 compliance actions were taken in 7,877 establishments; monetary violations amounting to $8.6 million were disclosed in 711 establishments involving 1,908 individuals in the amount of $3.5 million in 418 establishments. In the transition quarter, July–September 1976, an additional 284 persons were found due over $1 million as a result of ADEA violations.
>
> Non-monetary discriminatory practices were found in 1,894 establishments; 2,351 individuals were aided; and 31,964 job opportunities made available by the removal of discriminatory age barriers.
>
> Illegal advertising was the most common discriminatory practice disclosed, 903 instances; followed by refusals to hire, 552 instances; and illegal discharges, 500 instances.[216]

The Comprehensive Employment and Training Act also prohibits discrimination on the basis of age in its programs, but it appears that such discrimination does occur and is frequently the result of discrimination by public and private employers. Secretary of Labor Ray Marshall told the Commission:

> . . .a significant number of the CETA complaints received in the regions and the national office con-

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[214] Age Discrimination in Employment Act of 1967, Pub. L. No. 90–202, 81 Stat. 602 [codified at 29 U.S.C. §§621–634 (1970)].

[215] For reports that have documented the existence of age discrimination in employment, see U.S., Congress, House, Committee on Education and Labor, Select Subcommittee on Labor, *Employment Problems of the Older Worker*, 89th Cong., 1st sess., 1965, pp. 25–30 and 237–387; U.S., Department of Labor, Employment Standards Administration, *Questions and Answers Relating to Proposed Amendments to the Age Discrimination in Employment Act of 1967: Report to the Subcommittee on Labor of the United States Senate Committee on Human Resources* (1977), pp. 17, 19; and U.S., Department of Labor, Manpower Administration, *The Pre-Retirement Years*, vol. 4, prepared by Herbert S. Parnes (Washington, D.C.: Government Printing Office, 1975), p. 3.

[216] U.S., Department of Labor, Employment Standards Administration, *Age Discrimination in Employment Act of 1967, A Report Covering Activities under the Act During 1976* (1977), p. 3.

> cern age discrimination. The age complaints include both those involving participants and potential participants, and those involving program staff persons and potential staff persons.[217]

Other witnesses at the Commission's public hearings and persons interviewed during the field study indicated that, although employers were subtle about what they told persons interviewing for jobs, age was a factor in the decisions made by both the units of government hiring persons for public service employment slots and public and private employers. For example, Lawrence Borom, executive director of the Urban League of Colorado, testified that the Urban League, as a community-based organization that contracts with the training and public service employment programs of CETA, has found it difficult to place retired military people in Denver because "they are not the 25-year-old or the 22-year-old."[218] Mr. Borom went on to say:

> We see a considerable degree of age discrimination that goes on in the private sector even though it is not announced, obviously. It is not overtly announced, "you are too old to come to work for us," but the kind of responses we get to candidates that we are referring to various employers indicate to us that those employers have drawn specific kinds of lines based on the age of workers that they are looking for. . . .[219]

Guardie Banister, an equal employment opportunity specialist with the Office of Investigation and Compliance of the Department of Labor in Denver and a former staff member of the Wyoming State Employment Security Office, said that public agencies "have all kinds of theories as to why they don't want to hire the older worker," including the theory that an older worker, if hired, would not be able to qualify to receive pension benefits.[220]

Asked about the effect of outside employment markets on the operation of the CETA program, William Haltigan, Department of Labor official in San Francisco, testified:

> The CETA program operates in the economic-social environment that it operates in and. . .if there are difficulties in older workers getting jobs. . .those difficulties will be reflected in the difficulty with which. . .older people [are placed] as far as the CETA program is concerned.[221]

Some CETA plans also recognized discriminatory attitudes of employers. For example, the fiscal year 1977 Title I Plan for the Jackson, Mississippi, Manpower Consortium included a Senior Aides program funded with a combination of CETA Title I funds and funds provided under the Older Americans Act Title IX Senior Community Service Employment Program. The plan described eligible persons

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[217] Marshall Statement, *Washington, D.C. Hearing*, vol. II.

[218] Lawrence Borom Testimony, *Denver Hearing*, p. 199.

[219] Ibid.

[220] Guardie Banister Testimony, *Denver Hearing*, p. 189.

[221] Haltigan Testimony, *San Francisco Hearing*, p. 42.

55 or over as individuals who "would not normally be selected by employers due to age and/or work history."[222] The plan went on:

> . . .while termination [from participation in the Senior Aides program after being in the program for 12 months] will result in referral to the Employment Service for placement services, very little is expected due to their age factor.[223]

The *Fiscal Year 1976 Annual Report to the Governor on the Comprehensive Employment and Training Act* for the State of Washington noted with regard to persons 45 or over: "Although this age group generally has more experience and training, many older workers have difficulty finding employment because of employer resistance to hiring persons over 45."[224]

Part of employer resistance to hiring workers 45 or over was attributed to mandatory retirement policies. An administrator in the King-Snohomish Manpower Consortium said that the older a person is, the easier it is to re-enter the labor market but only to a certain point—50 or 55. People begin to have problems at that age, she said, because they are "only a few years away from retirement."[225]

Many agencies awarded slots by prime sponsors are also given complete or partial responsibility for placing CETA enrollees in unsubsidized employment. In this regard, the director of one program said that mandatory retirement policies contributed to a low participation rate by older persons because public agencies and nonprofit, private agencies required to absorb CETA enrollees tend to accept those who meet their normal personnel requirements.[226]

Seven of the nine sites visited by Commission staff had mandatory retirement policies covering employment in the public sector; many private employers also have such policies.[227] Where a unit of local government has a mandatory retirement policy, people beyond that age are often excluded from the CETA program, because employers do not want to enroll individuals who cannot be absorbed later into the regular work force. Where private employers have such policies, the same result follows. Because the ability of program administrators to place enrollees in the public or private sector is severely restricted, the numbers of CETA enrollees from older age groups are restricted. At one site where the government unit administering a public service employment program had a mandatory retirement age of 65, the program director said that not only persons over 65 but also those between 60 and 65 are not hired because they are approaching the mandatory retirement age. She explained, "Who wants to hire a 63-year-old when that person will be forced to retire at 65?"[228] Two directors of public service employment programs remarked that the age discrimination problems in CETA will continue until mandatory retirement is eliminated.[229]

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[222] Jackson, Mississippi, Manpower Consortium, *Title I CETA Plan for Fiscal Year 1977*, p. 20. Senior Aides is the name of the part-time employment program for persons 55 or over administered by the National Council of Senior Citizens, which receives funds authorized under Title IX of the Older Americans Act, which is administered by the Department of Labor.

[223] Ibid.

[224] Washington State Employment Development Council, Office of Community Development, *Fiscal Year 1976 Annual Report to the Governor on the Comprehensive Employment and Training Act* (1976), p. 11.

[225] Hoerschelmann Interview.

[226] Ball Interview.

[227] The areas where there were mandatory retirement policies were King County, Wash.; St. Louis, Mo.; San Francisco, Calif.; Denver, Colo.; Jackson, Miss.; San Antonio, Tex.; and Chicago, Ill. Since the time that Commission staff were in these areas, the Maine State legislature has overriden the Governor's veto of legislation to eliminate age-based mandatory retirement for State employees, and California has enacted legislation banning mandatory retirement on the basis of age.
A 1977 report by the Select Committee on Aging of the U.S. House of Representatives cited data from a Bureau of Labor Statistics study of private pension plan provisions showing that 41 percent of the almost 21 million workers covered by these plans had jobs with mandatory retirement policies, and data from a 1972 study of State and local retirement systems showing that most have a mandatory retirement age. U.S., Congress, House, Select Committee on Aging, *Mandatory Retirement: The Social and Human Cost of Enforced Illness*, 95th Cong., 1st sess., Comm. Pub. No. 91, 1977, pp. 4–6.

Several respondents also said that young persons, principally those under the age of 19, experience age discrimination in employment, which influences their ability to participate in CETA public service employment programs.

Martha Wadsworth, supervisor of the Southeast Youth Employment Service in Denver, testified that youth are discriminated against in employment because "many employers do not want to take the risk of hiring a young person if they can find somebody older and more reliable, and [are] not willing to take the time to train younger persons."[230]

Staff of two agencies administering CETA programs also indicated that young persons may be discriminated against on the basis of age by employers, because they think that young people are unskilled, immature, and likely to have a high absenteeism rate.[231]

In its *Interim Strategic Plan, 1977–1979*, the Department of Labor recognizes the discrimination that exists against both older workers and younger workers in the public and private employment markets. Discrimination against older workers, as reported in the plan, is reflected in the fact that older unemployed workers find themselves at a comparative disadvantage with younger or more skilled workers and remain unemployed longer as a result.[232] With regard to younger workers, the plan reported that they face employer preferences toward "older youth rather than teenagers," and that "this, when added to race and sex discrimination, makes job-seeking particularly difficult for younger, black, and female workers."[233] The Department noted:

> [T]here is a *strong aging effect* in the aggregate. Across all age-sex-race groups, unemployment rates decline sharply as youths go from 16–17 to

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[228] Ball Interview.

[229] McPherson Interview; Canada Interview.

[230] Martha Wadsworth Testimony, *Denver Hearing*, p. 187.

[231] Hoerschelmann Interview; Canada Interview.

[232] U.S., Department of Labor, Employment and Training Administration, *Interim Strategic Plan, 1977–1979* (1976), p. 31 (hereafter cited as *Interim Plan*).

[233] Ibid., p. 8.

> 20–24. Thus, for *most* youths, high initial unemployment rates apparently do not presage continuing labor market difficulties in later life.[234]

Recent unemployment data, however, have shown slight increases in unemployment among persons 22 to 44, which may indicate that this problem has become a chronic unemployment problem for those youth who were 19 to 22; now older, they remain without jobs.

Benefits and The Return on the Government's Investment

What programs will cost and what groups, if served, will provide a positive return on the government's investment concerned many CETA program administrators.

Cost was a consideration in all programs, but particularly in the Title I training program. Prime sponsors' requests for Title I funds are reviewed annually, and one criterion for refunding is the cost of various types of training and of placement.[235] Arthur Douglas, Associate Administrator of the Employment and Training Administration of the Department of Labor in San Francisco, described the attitude of prime sponsors toward cost:

> You. . .get into the whole concept of costs and you have to deal with it as a generality and an average. A prime sponsor, I am sure, knows that some segment of the population he has to deal with will require much more in the way of monies and services than others. But we look at a range of costs, an average, and if they are extremely high, we question why those costs are so high.
>
> . . .[T]here is this emphasis on our part basically to keep costs down and to get placements up because that is what we believe the program is.[236]

Mr. Douglas stated that different costs for training would depend on what the individual brings to the training assignment and not his or her age.[237] The Commission determined, however, that taking into account the costs of training does have indirect consequences on the age distributions of persons who are served. The director of program development and administration in Seattle said that because it costs more to provide classroom training, which frequently includes a subsidy for living or travel expenses, than to provide work experience, her program has concentrated on providing work experience.[238] In fact, this is the case in most prime sponsor agencies; 48 percent of enrollees in Title I programs were in work experience programs in fiscal year 1976, compared to 32 percent in classroom training.[239] Work experience is primarily utilized by CETA prime sponsors as the means for serving youth.[240]

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[234] Ibid., p. 7.

[235] U.S., Department of Labor, Employment and Training Administration, *Field Memorandum No. 216-77*, Mar. 23, 1977.

[236] Douglas Testimony, *San Francisco Hearing*, p. 45.

[237] Ibid., p. 46.

[238] Hoerschelmann Interview.

[239] *Employment and Training Report, 1977*, pp. 45–46.

[240] *Interim Plan*, pp. 16, 26.

Table 4.12
Percent Distribution of CETA Title I Enrollees by Age, St. Louis, Missouri, Fiscal Year 1976

Age Group	Title I Enrollees
All Ages	100.0%
Under 19	13.7
19-21	22.9
22-44	57.6
45-54	3.5
55-64	1.1
65+	1.1

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

With their concern about costs generally, CETA program administrators also expressed their concern about spending funds to maximize the Federal investment. In St. Louis, the Title I program limited participation by persons under 18 and restricted certain training programs to persons 22 or over. The program's assistant director said that persons under 18 were generally not served because training involves a heavy investment in a client—sometimes $4,000 to $5,000—and most younger people are not mature enough to complete a program.[241] Table 4.12 shows the enrollment in the Title I program for fiscal year 1976.

In Seattle, the 16 to 24 age group was selected as one of the priority groups to which the Title I program would be directed. The director of the prime sponsor agency said that in selecting this group a consideration had been the work life remaining for those individuals compared to the work life remaining for 45-year-olds. Because more working years were potentially ahead for them, 16-to-24-year olds were selected as the agency's priority. The director also expressed his view that after an individual reached the age of 45, the limited tax payback ability of that individual would make training no longer cost-effective. Although a 45-year-old might expect to work only 20 years after receiving training, a younger person would presumably work and pay taxes for a longer period of time.[242] Data on Title I participation at this site show very low participation by persons 45 or over. (See table 4.13.)

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[241] Canada Interview.

[242] McPherson Interview.

Table 4.13
Percent Distribution of CETA Title I Enrollees by Age, King-Snohomish County, Washington, Fiscal Year 1976

Age Group	Title I Enrollees
All Ages	100.0%
Under 19	32.0
19-21	21.7
22-44	43.0
45-54	2.7
55-64	0.6
65+	0.0

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

A planner for the Maine balance-of-State program said that the prime sponsor cannot serve everyone, so highest priority is placed on serving young and "primary working age" individuals, because "the marginal return on investment is greater if the prime sponsor concentrates on younger workers."[243] Data for the site show that the prime sponsor concentrated on these groups in both training and public service employment programs. Youth under 19 and older persons over 65 are very much underrepresented. (See table 4.14.)

Arthur Douglas, an official of the Department of Labor in San Francisco, also suggested that return on investment is a factor that motivates prime sponsors' decisions on whom to serve. He said:

> . . .an unemployed female head of household with dependent children is an example of a type of person that many primes believe. . .has great priority for service and, in point of fact. . .there's a great payoff for training female heads of households with dependent children who are unemployed. . . .[244]

Reliance on Age Categorical Programs

The Senior Community Service Employment Program, authorized by Title IX of the Older Americans Act, provides part-

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[243] Dorrer Interview.

[244] Douglas Testimony, *San Francisco Hearing*, p. 46.

Table 4.14
Percent Distribution of CETA Titles I, II, and VI Enrollees by Age, Maine Balance-of-State Program, Fiscal Year 1976

Age Group	Title I Enrollees	Title II Enrollees	Title VI Enrollees
All Ages	100.0%	100.0%	100.0%
Under 19	9.9	0.8	0.7
19-21	28.7	12.5	10.7
22-44	54.3	67.2	70.6
45-54	4.8	11.1	9.8
55-64	2.1	7.0	6.7
65+	0.3	1.4	1.5

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

time community service jobs for low-income persons 55 or over.[245] The Department of Labor administers the program. The existence of this age categorical program was identified by some CETA program administrators as one reason for the low percentage of older participants in CETA programs. The administrators said decisions about types of activities that should be supported under Titles I, II, and VI took into consideration whether a Title IX program was available. If it were, CETA funds for older persons were reduced. This was despite the fact that $85.9 million was appropriated for the Title IX program in fiscal year 1976, compared to $4.8 billion for Titles I, II, and VI with an additional $495 million for the transition quarter.[246]

The director of an Emergency Employment Act office in San Antonio said that because the community action agency in his city had Title IX funds for older workers, he and the manpower planning council believed it would be a duplication of effort to concentrate on the same age group.[247] The fiscal year 1976 participation rates for persons 45 or over in the Title I, II, and VI programs of the prime sponsor agency are shown in table 4.15.

The director of program development and administration in another prime sponsor agency said that the Green Thumb

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[245] 42 U.S.C. §3056 (Supp. V 1975).

[246] Information on appropriations was supplied by the U.S., Department of Labor, Employment and Training Administration, Office of Administration and Management.

[247] Garcia Interview.

Table 4.15
Percent Distribution of CETA Titles I, II, and VI Enrollees by Age, San Antonio, Texas, Fiscal Year 1976

Age Group	Title I Enrollees	Title II Enrollees	Title VI Enrollees
45-54	6.8	0.0	3.9
55-64	1.3	1.0	1.2
65+	0.2	0.0	0.0

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

program (a Title IX contractor) provides employment opportunities for older persons in that area.[248] She did not say that the prime sponsor, as a result, had no responsibility to serve older persons, but seemed to consider the existence of this resource as lessening the need of the prime sponsor to serve older persons. Participation levels for this area for those 45 or over are shown in table 4.16.

The dependence on age categorical programs to serve certain age groups was demonstrated in another way by one prime sponsor agency. This agency had developed its priorities on an assessment of manpower needs of individuals between 14 and 55. Persons over 55 had not been included. When Title IX funds became available to States in fiscal year 1977, however, the prime sponsor developed a proposal showing that an older workers' program was needed in the area and received a Title IX grant of $100,000 to provide part-time employment for persons 55 or over.[249]

An official of the Department of Labor in Kansas City said that in deciding whom to serve, program administrators could take into account other programs and plan

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[248] Hoerschelmann Interview.

[249] Thibodeau Interview; Dorrer Interview. In fiscal year 1977, there was much controversy over whether funds under Title IX of the Older Americans Act, which is administered by the Department of Labor, should be awarded to the States or whether they should continue to be awarded to the national organizations that had received the funds in the past. The position that was reached was to provide funds both to national organizations and to the States.

Table 4.16
Percent Distribution of CETA Titles I, II, and VI Enrollees by Age, King-Snohomish County, Washington, Fiscal Year 1976

Age Group	Title I Enrollees	Title II Enrollees	Title VI Enrollees
45-54	2.7	9.0	7.0
55-64	0.6	3.5	2.7
65+	0.6	0.3	0.3

Source: U.S., Department of Labor, Employment and Training Administration, unpublished data.

to serve groups not already served by other programs and activities.[250] He and other Federal regional staff cited Title IX as one such program.[251]

Secretary of Labor Ray Marshall, however, told the Commission:

> We are concerned that the senior community service employment program may, by its very existence, give CETA prime sponsors a rationale for ignoring the elderly, and, thereby may cause an overall reduction of employment-related services for this group. However, we are committed to doing what we can to prevent this.[252]

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[250] Ray Lybarger, Deputy Associate Regional Administrator for Iowa, Employment and Training Administration, Department of Labor, interview in Kansas City, Mo., Apr. 14, 1977.

[251] Lybarger; Cecil Reed, Asssociate Regional Administrator for Area Operations; Bob Johnson, Deputy Associate Regional Administrator for Missouri; Lynn Curtis, Federal representative to Kansas Balance-of-State Program, Employment and Training Administration, Department of Labor, interview in Kansas City, Mo., Apr. 14, 1977.

[252] Marshall Testimony, *Washington, D.C. Hearing*, p. 62.

Chapter 5

Education

Two educational services programs—adult basic education and vocational education—and the field of higher education were included in the Commission's study. The adult basic education program, authorized by the Adult Education Act of 1966, as amended, provides grants to States for programs to enable persons aged 16 or over to continue their education to at least the completion of secondary school.[1] The State vocational education basic grant program, authorized by the Vocational Education Act of 1963, as amended,[2] provides grants to States to assist in the provision of vocational education for persons of all ages in need of such services.[3] The study examined the field of higher education in a different manner from the other federally-assisted programs, focusing on admission policies and opportunities for nontraditional students at undergraduate and graduate schools.

Review of the two educational services programs found that older persons account for a substantial proportion of the population who could be served by the adult basic education program, yet they make up a small percentage of the participants. Training programs subsidized by the vocational education program are interpreted to mean imparting skills to younger people who have never worked. In regard to higher education, admission to some medical schools is denied on the basis of age. Admission to graduate and law schools is often unfavorable for older students, after certain ages. It was found that despite these restrictions, some institutions of higher education are increasingly providing new opportunities to meet the needs of older, nontraditional students.

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[1] Adult Education Act of 1966, Pub. L. No. 89–750, 80 Stat. 1217 [codified at 20 U.S.C. §§1201–1211 (1970 and Supp. V 1975)].

[2] Vocational Education Act of 1963, Pub. L. No. 88–210, 77 Stat. 403 [codified at 20 U.S.C. §§1241–1393f (1970 and Supp. V 1975)]. Amended in its entirety by the Education Amendments of 1976, Pub. L. No. 94–482, 90 Stat. 2169 [to be codified in 20 U.S.C. §§2301–2461].

[3] 20 U.S.C. §1261 (1970).

Program Description

Currently, responsibility and authority for public education rests primarily with the State and local governments.[4] The Federal role in education was formally stated in 1970, when the Congress enacted a prohibition against Federal control of education:

> No provision of any applicable act[5] shall be construed to authorize any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over the curriculum, program of instruction, administration, or personnel of any educational institution, school or school system, or over the selection of library resources, textbooks, or other printed or published instructional materials by any educational institution or school system, or to require the assignment or transportation of students or teachers in order to overcome racial imbalance.[6]

In an interview with Commission staff, an Office of Education official confirmed the limited role of the Federal Government in education. He said that the Federal Government supports nationally identified needs that are not adequately met by the States, such as provision of services to the disadvantaged, the bilingual, and the handicapped. He also added that the Federal Government has virtually no authority to mandate how States implement programs or expend Federal funds.[7]

One area in which Federal funds are made available to meet specific educational needs is in the field of adult basic education. The purpose of the adult basic education program is to expand existing programs and encourage new public education programs that will enable adults 16 or over to continue their education to at least the completion of secondary school and to "make available the means to secure training that will enable them to become more employable, productive, and responsible citizens."[8] To meet these objectives, the Commissioner of Education is authorized to make grants to States with approved annual plans to meet 90 percent of the cost of adult basic and adult education programs.[9] Not all local school districts use the same grade levels to distinguish between elementary (or basic) education and secondary education; however, basic education is usually considered to encompass kindergarten through the eighth grade, and secondary education is usually defined as grades 9 through 12.[10] The statute defines adult basic education as:

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[4] U.S., Congress, Congressional Budget Office, *Elementary, Secondary and Vocational Education: An Examination of Alternative Federal Roles*, 94th Cong. 2nd Sess., 1977, p. xi.

[5] The Education Amendments of 1976, Pub. L. No. 94–482, Title IV §409(b), 90 Stat. 2230 substituted the phrase "any applicable program" for the previous listing of acts covered. These were ". . .the Act of September 30, 1950, Public Law 874, Eighty-first Congress; the National Defense Education Act of 1958; Act of September 23, 1950, Public Law No. 815, Eighty-first Congress; the Higher Education Facilities Act of 1963; the Elementary and Secondary Education Act of 1965; the Higher Education Act of 1965; the International Education Act of 1966; the Emergency School Aid Act; or the Vocational Education Act of 1963." 20 U.S.C. §1232a (Supp. V 1975).

[6] 20 U.S.C. §1232a (Supp. V 1975).

[7] Dr. Alfred Alford, Assistant Commissioner for Legislation, U.S. Office of Education, interview in Washington, D.C., Aug. 4, 1977.

[8] 20 U.S.C. §§1201, 1202(a) (1970).

[9] 20 U.S.C. §§1203 (Supp V 1975), 1206(a) (1970), 1205 (1970); and 45 C.F.R. §166.12 (1976).

> . . .education for adults whose inability to speak, read, or write the English language constitutes a substantial impairment of their ability to get or retain employment commensurate with their real ability, which is designed to help eliminate such inability and raise the level of education of such individuals with a view to making them less likely to become dependent on others, to improving their ability to benefit from occupational training and otherwise increasing their opportunities for more productive and profitable employment, and to making them better able to meet their adult responsibilities.[11]

A State's plan for adult education is submitted through its State education agency and must set forth a program for the use of the grant. The plan must provide that the adult education program will be administered by the State education agency, defined as the agency responsible for public elementary and secondary schools, or a separate agency responsible for adult education, if there is one. Also, the plan must specify that special emphasis will be given to adult basic education programs and provide that no more than 20 percent of the State's allotment will be spent for secondary school equivalency certification programs.[12]

Another area in which Federal funds are made available to meet specific educational needs is vocational education. The purpose of the vocational education program is to provide Federal grants to States to assist them in providing programs to persons of all ages who need such education and training.[13] To participate in the program, a State must submit an annual plan to the Commissioner of Education which describes the State's programs, services, and activities. The plan must provide that the vocational education program will be administered by either a State board responsible for vocational education or the local education agencies that administer public elementary and secondary schools.[14] Dr. Ernest Boyer, Commissioner of Education, testified that the plan is usually administered or supervised by the State and local education agencies.[15]

After the Commissioner of Education has approved a State plan, Federal funds are made available to the State to meet 50 percent of the cost of providing vocational education activities specified in the plan.[16]

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[10] U.S., General Accounting Office, *The Adult Basic Education Program: Progress in Reducing Illiteracy and Improvement Needed* (1975), p. 1 (hereafter cited as *Adult Basic Education Program*); Dr. Robert Maroney, director, Division of Occupational, Handicapped, and Development Programs, Office of Education, and Dr. George Mayeske, Director, Division of Elementary and Secondary Programs, Office of Planning, Office of Education interview in Washington, D.C., Aug. 2, 1977 (hereafter cited as Maroney-Mayeske Interview); 45 C.F.R. §100.1 (1976).

[11] 20 U.S.C. §1202(c) (1970).

[12] 20 U.S.C. §§1205(a); 1202(h) (1970 and Supp. V 1975).

[13] 20 U.S.C. §1261 (1970). The State Vocational Education program was amended in its entirety by the Education Amendments of 1976, Pub. L. No. 94-482, 90 Stat. 2169 [codified as 20 U.S.C. §§2301-2461] effective Oct. 1, 1977. The purpose as stated was retained although expanded to define specific groups to be included.

[14] 20 U.S.C. §§1263(a), 1248(8) and (9) (1970).

[15] Dr. Ernest Boyer, testimony, *Hearing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Sept. 26-28, 1977, vol. I, p. 123. (hereafter cited as *Washington, D.C. Hearing*).

Although traditionally within the province of State and local governments and private institutions, higher education has seen the Federal Government assume an increasingly active financial role. The Morril Act of 1862, which established the land grant college system, marked the beginning of major Federal assistance for higher education.[17] Subsequent involvement in higher education came about primarily as a result of the educational benefits for veterans and financial support for research, usually defense or health oriented.[18] Federal assistance is in the form of aid for students or direct support to the institution.

In the 1959–60 school year the total expenditures of institutions of higher education were less than $10 billion; expenditures for the 1976–77 year were estimated to have been $49.2 billion. According to the National Center for Education Statistics:

> The Federal share of these expenditures has grown from 14.9 percent in 1959–60 to a high of 19.1 percent in 1967–68 and [was] expected to drop to 15.0 percent in 1976–77.[19]

For the 1976–77 school year, the remainder of the funds was reported as 30 percent from State governments, 4 percent from local governments, and 50 percent from all other sources.[20]

Federal administration of the educational services and higher education programs is performed by the Office of Education in the Department of Health, Education, and Welfare. (A list of the institutions of higher education covered in the Commission's study is included as appendix C.)

Summary of the Record

Program Participants

Participant data were examined for both educational services programs—adult education and vocational education. However, a comparison with an estimated eligible population was possible only for adult education. The examination was limited because there is a serious lack of reliable data on Federal educational services programs, especially by age.[21]

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[16] 20 U.S.C. §1264 (1970).

[17] Morril Act of 1862, ch. 130, §1, 12 Stat. 503 [codified at 7 U.S.C. §301–305, 307, 308 (1970)].

[18] American Council on Education, *A Cabinet Department of Education: Analysis and Proposal*, 1976, pp. 21–24.

[19] U.S., Department of Health, Education, and Welfare, Education Division, National Center for Education Statistics, *The Condition of Education*, 1977 edition), p. 54.

[20] Ibid., p. 57.

[21] The General Accounting Office identified the problem with Office of Education program statistics in their report, *Adult Basic Education Program*, pp. 19–20. Unable to locate complete data, the Commission submitted a formal request to the Department of Health, Education, and Welfare. Letter from Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, to Mary Berry, Assistant Secretary for Education, Department of Health, Education, and Welfare, Aug. 14, 1977. (Commission files. The Commission received no response to the letter, despite several follow-up telephone calls.)

The Department of Health, Education, and Welfare estimated the number of participants by age groups in the adult education program for school year 1976–77. The department's budget justification for fiscal year 1978 included estimates of the participant population for the following 2 years which were based on the same age categories as used in the 1976–1977 estimates.[22] Table 5.1 contains these participant estimates and the corresponding percentage distributions for the age groups reported. The data show that the majority of the program participants were estimated to be under 35, and that only 4 percent were 65 or older. Moreover, the department did not anticipate any changes in the age composition of the program participants.

To determine if age were a factor in the delivery of adult educational services, Commission staff compared the program participant estimates with two different population bases representing those eligible for services. Since the statute provides that the adult education program is intended to serve those who have not completed secondary education,[23] the population distribution by the highest grade of school completed was used. Because Federal regulations allow participation by those who may be secondary school graduates but are "functioning at less than a secondary competency,"[24] participant data were also compared to data based on levels of "functional competency." This is defined as not simply the ability to read or write at some specified level, but the ability to apply communication, computation, problem solving, and interpersonal skills to everyday life situations, such as balancing a checkbook or looking for a job.[25]

The population that has not completed high school can be divided into two subgroups that correspond to the basic education (kindergarten through eighth grade) and secondary instruction (grades 9 through 12) components of the adult education program. The Current Population Survey for March 1977 collected data on the population aged 14 or older by highest grade of school completed.[26] As shown in table 5.2, the median number of years of school completed increased with age until the age of 30 when the median year completed began to decline. Except for the age groups under age 18 (which includes those still attending secondary school), the only other age groups with median grade completions below the secondary level are those 65 or over.

Table 5.3 compares data for 1970 and 1977 from two sources for the population of persons aged 16 or older by the highest year of school completed. The National Advisory Council on Adult Education developed the 1970 estimates based on census data. From those estimates they

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[22] U.S., Department of Health, Education, and Welfare, Education Division, *Justifications of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1978 Revised*, p. 190, (hereafter cited as *Justifications of Appropriation Estimates*).

[23] 20 U.S.C. §§1201, 1202(b) (1970).

[24] 45 C.F.R. §166.12(c) (1976).

[25] Dr. Norvell Northcutt and others, *Adult Functional Competency: A Summary* (The University of Texas at Austin, 1975) pp. 1, 4, and Tab A (hereafter cited as *Adult Functional Competency*).

[26] U.S., Department of Commerce, Bureau of the Census, *Education Attainment in the United States, March 1977 and 1976*, Current Population Reports, Series P-20, no. 314, p. 51.

Table 5.1

Estimated Participation in the Adult Education Program by Age for School Years 1976-77, 1977-78 and 1978-79

Age Groups	School Year 1976-77	School Year 1977-78	School Year 1978-79
Number			
Estimated Total Participants	1,037,000	1,166,000	1,116,000
16-24	342,210	384,780	394,780
25-34	228,140	256,520	256,520
35-44	155,550	174,900	174,900
45-54	165,920	186,560	186,560
55-64	103,700	116,600	116,600
65+	41,480	46,640	46,640
Percent Distribution			
All Ages	100%	100%	100%
16-24	33%	33%	33%
25-34	22	22	22
35-44	15	15	15
45-54	16	16	16
55-64	10	10	10
65+	4	4	4

Source: U.S., Department of Health, Education, and Welfare, Education Division, *Justifications of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1978, Revised*, p. 190.

Table 5.2

Median School Years Completed for Persons 14 Years or Older by Age, March 1977

Age Group	Median School Years Completed
All Ages	12.3
14-15	8.5
16-17	10.4
18-19	12.2
20-24	12.8
25-29	12.9
30-34	12.8
35-39	12.6
40-44	12.5
45-49	12.4
50-54	12.3
55-59	12.3
60-64	12.1
65-69	10.7
70-74	9.7
75+	8.7

Source: U.S., Department of Commerce, Bureau of the Census, *Educational Attainment in the United States, March 1977 and 1976*, Current Population Reports, Series P-20, No. 314, 1977, p. 7.

Table 5.3

Distribution of Persons Aged 16 or Older Who Have Not Completed Grade 12, Calendar Years 1970 and 1977

Age Group	Persons Who Have Not Completed School, 1970[a]	Persons Who Have Not Completed School, 1977[b]
All Ages	100.0%	100.0%
16-24	8.5	25.3
25-34	11.9	9.5
35-44	15.3	10.7
45-64	37.9	30.2
65+	26.3	24.4

Source: [a] National Advisory Council on Adult Education, *A Target Population in Adult Education*, 1974, p. 153.

[b] U.S., Department of Commerce, Bureau of the Census, *Educational Attainment in the United States*, March 1977 and 1976, Current Population Reports, Series P-20, No. 314, 1977, Table 1, p. 7; and Bureau of the Census, unpublished data from the current population survey, March 1977.

Table 5.4
Percent Distribution of the Population Aged 16 or Older Who Have Not Completed Primary or Secondary School by Age, March 1977, and Participants in the Adult Basic Education Program by Age, School Year 1976-77

Age Group	Those Who Have Not Completed Grade 12[a]			ABE[b] Participants
	Total	Less than Grade 8	Grade 8 But Less Than Grade 12	
All Ages	100.0%	100.0%	100.0%	100%
16-24	25.3	4.6	31.7	33
25-34	9.5	6.9	10.2	22
35-44	10.7	10.1	11.0	15
45-54	14.7	16.6	14.1	16
55-64	15.5	20.3	14.0	10
65+	24.4	41.5	19.0	4

Source: [a] U.S., Department of Commerce, Bureau of the Census, *Educational Attainment in the United States, March 1977 and 1976*, Current Population Reports, Series P-20, No. 314, 1977, Table 1, p. 7; and Bureau of the Census unpublished data from the current population survey, March 1977.

[b] U.S., Department of Health, Education, and Welfare, Education Division, *Justifications of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1978, Revised*, p. 190.

determined that 54.3 million persons aged 16 or over had not completed high school and were not enrolled in school. Of this number, only 24 million (44.2 percent) were determined to be gainfully employed.[27]

The 1977 Current Population Survey reported the highest grade completed, not just attended. Thus, data for persons reported to have completed grade 11 or less are used to represent the population who have not completed a secondary level education. The data do not distinguish between those currently attending school and those who are not. This means that persons who would be ineligible for adult education services because they are still attending school are included in the eligible population estimates, but this most probably has increased only the representation of the youngest age group.

A comparison between the 1970 data, which exclude those enrolled in school, and the 1977 data, which do not, supports this assumption. The 1970 data indicated that when those persons not enrolled in school were subtracted from the total who had not completed their secondary education, the representation of the 16 to 24 age group decreased.

Table 5.4 compares data on the highest grade completed for persons 16 or over with the adult education program participant data. Even though they include some persons still attending school, the 1977 data were used to represent the eligible population because they are more recent, have narrower age groupings for persons 45 or older, and have details on different levels completed. Persons up to age 55 are served by the adult education program in greater proportions than they represent in the eligible population, while, persons 55 or over, who constitute a large proportion of the population eligible for adult educational services, are underrepresented among participants. Moreover, they account for the majority of persons who have not completed eighth grade, which would appear to make them the majority of the group in need of basic education, the program's priority. Persons 55 or older comprise, however, only 14 percent of all adult education participants.

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[27] National Advisory Council on Adult Education, *Beyond the Verge* (1977 Annual Report), p. 2 (hereafter cited as *Beyond the Verge*).

The other estimate of the population in need of adult educational services is derived from a national survey of adult functional competence. The Office of Education funded the University of Texas at Austin to conduct a 5-year study to define adult literacy in terms of an individual's ability to cope with activities encountered in daily living and to determine the competency of the U.S. adult population (aged 18 to 65) based on the measures developed.[28] In its budget justifications for fiscal year 1978, the Department of Health, Education, and Welfare reported that the study "accurately measured the educational needs of adults in the United States."[29] Furthermore, the study's findings and recommended program were incorporated into the Office of Education's national priorities in adult education, which a State education agency "may take. . .into consideration" when developing its annual plan.[30]

The resulting project report described three "adult performance levels" of functional competency, that is, the ability to function in everyday life situations. The three levels are:

- **Functionally incompetent,** which includes adults who function with difficulty. This level was found to be associated with income at or below the poverty level, education of 8 years or less, and unemployment or "low status" occupations.

- **Marginally competent,** which includes adults who are functioning at the minimal level necessary to cope with everyday life. This level was found to be associated with income higher than the poverty level but with no discretionary income, completion of 9 to 11 years of school, and "medial status" occupations.

- **Proficient,** which includes adults who have mastered the competency objectives to a high degree. It was found to be associated with higher levels of income, education (at least completion of grade 12), and job status.[31]

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[28] Dr. Northcutt, *Adult Functional Competency* and Dr. Norvell Northcutt and others, *The Adult Performance Level Competency-Based High School Diploma Pilot Project* (The University of Texas at Austin, 1976), p. 1.

[29] *Justifications of Appropriation Estimates*, p. 189.

[30] 45 C.F.R. §166.25, and Part 166 Appendix B (1976).

The survey, using the measures of adult competency, found that one out of five adults (aged 18 to 65) lacked the skills and knowledge needed to function competently, and another 33.9 percent were only marginally competent.[32] (See table 5.5.) The Department of Health, Education, and Welfare reported that the survey further indicated that 63.2 million adults between the ages of 18 and 65 lack the educational competencies required to be proficient in meeting everyday requirements, with 23.2 million of these classified as functionally incompetent.[33]

Although the age categories used to present the adult performance levels are not the same as those used to report the adult education program participant population (see table 5.1), some general observations can be made about the two. The largest percentage who are functionally incompetent (35 percent) or marginally competent (40 percent) occurs among those in the 60- to 65-year-old range; yet persons between 55 and 65 account for only 10 percent of adult education program participants.

The study did not determine functional competency for persons over age 65; however, based on data trends shown for their closest age cohorts (55 to 65), it is assumed that illiteracy rates are even higher for this age group. They make up only 4 percent of the adult education participant population.

Although very limited, available data on the vocational education program indicate that resources are concentrated on younger persons. For example, of an estimated 17 million persons to be enrolled in vocational education programs in the 1978–79 school year, approximately 9.2 million will be secondary education students, 3.1 million will be postsecondary education students, and 4.7 million will be adult participants.[34] Although age groups are not identified for these categories, officials of the Federal Office of Education said that most States do, in fact, focus their vocational education activities at the secondary school level.[35]

The review of higher education did not include an attempt to analyze the age composition of students at institutions of higher education; however, the following trends were identified in literature relevant to this area. The term "older," as used in the following statements, was not defined; however, the traditional ages associated with college attendance are 18 to 25. Students over 25 are considered to be older, "nontraditional students."

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[31] Dr. Northcutt, *Adult Functional Competency*, p. 5. This report referred to the middle level as functionally not marginally competent; however, two other publications have substituted the term "marginally competent" for that level. One was written by a staff person of the Office of Education, Office of Public Affairs. Edith Roth, "APL: A Ferment in Education," reprinted from *American Education*, May 1976. The National Advisory Council on Adult Education also used the term "marginally competent." *Beyond the Verge*, p. 2.

[32] Dr. Northcutt, *Adult Functional Competency*, p. 6.

[33] *Justifications of Appropriation Estimates*, p. 189.

[34] Ibid., p. 178.

[35] Maroney-Mayeske Interview.

Table 5.5
Adult Performance Level
Competency Ratings For Persons 18 to 65 by Age

Age Group	Functionally Incompetent	Marginally Competent	Proficiently Competent
All Ages	20%	34%	46%
18-29	16	35	49
30-39	11	29	60
40-49	19	32	49
50-59	28	37	35
60-65	35	40	24

Source: Dr. Norvell Northcutt and others, *Adult Functional Competency: A Summary* (The University of Texas at Austin, 1975) p. 7.

- Enrollment of older part-time students in postsecondary education is increasing, while enrollment of younger full-time students is decreasing.[36]

- The majority of students currently enrolled in postsecondary institutions are adult students continuing their education on a part-time basis. One-third of all students in postsecondary institutions are between the ages of 25 and 34. One million are over the age of 35.[37]

- Decreased enrollment anong younger age groups is particularly noticeable among 18- and 19-year-olds. In 1955 this group made up 31.3 percent of enrollees and in 1965 increased to 39 percent. By 1974, however, 18- and 19-year-olds made up only 26.4 percent of students attending 2- and 4-year undergraduate and graduate schools.[38]

Narrow Interpretation of Broad Goals

The vocational education program authorizes grants to provide vocational training to persons of all ages; however, in practice this has been interpreted to mean imparting skills to younger people who have never worked, not retraining those who have. The statute itself recognizes the need for training of persons who have completed their formal education and are ready to enter the labor market and

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[36] National Advisory Council on Extension and Continuing Education, *Tenth Annual Report*, March 1976, p. 1 (hereafter cited as *Tenth Annual Report*).

[37] Ibid., p. 2.

[38] U.S., Department of Health, Education, and Welfare, National Center for Education Statistics, *The Condition of Education*, 1976 Edition, p. 88 (hereafter cited as *Condition of Education*).

"those who have already entered the labor market but need to upgrade their skills or learn new ones."[39]

As stated above, program data indicate that more than half of all persons enrolled in vocational education programs were secondary school students, and Federal officials confirmed that States focus their activities in secondary schools. Furthermore, Federal officials said that there has been a recent shift in program emphasis to prevocational training,[40] which now has the largest enrollment of any currently supported vocational education activity.[41] This shift in emphasis is directed toward preparing students at the junior high school level (usually ages 11 to 14) for regular vocational training. With this shift, the program appears to be expanding further its emphasis on the younger population despite the program's statutory purposes to serve all ages.

The Commissioner of Education, Dr. Ernest Boyer, testified that part of the explanation for the program's focus on some age groups relates to how services are administered. He said that the Federal Government provides grants to States for vocational education, and that the State education agency has the primary responsibility for awarding funds to the institutions that will provide the educational services. State education agencies depend on existing institutions for the actual delivery of services to recipients, and many of these institutions are high schools. As recalled by Dr. Boyer, 85 percent of vocational educational funds are delivered through high schools. He said that although such schools are not limited in theory to any age group, they tend to target on the population they are serving in their more general education activities.[42]

Admission to Medical Schools

Commission staff analyzed the entrance requirements of medical schools and found that 28 schools include statements in their entrance requirements that specify age as a consideration for admission.

Information on the ages of medical school applicants and on the ages of those who are accepted indicates that a high proportion are persons in the younger age groups. The Association of American Medical Colleges reports:

> . . .most accepted applicants are 27 years of age or younger. Over 90 percent of all applicants and almost 95 percent of all those accepted to the 1974–75 entering class were in that age range. Less than three percent of all applicants and about one percent of all acceptees were over age 31.[43]

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[39] 20 U.S.C. §1241 (1976). The Education Amendments of 1976, Pub. L. No. 94–482, 90 Stat. 2169 [to be codified at 20 U.S.C. §§2301–2461] amended the Vocational Education Act entirely, effective Oct. 1, 1977. The amended statute retains the language on retraining previous workers while it also specifies a new program emphasis for several categories of women, including those who are single heads of households, have been homemakers, or wish to seek employment in jobs not traditionally open to women. 90 Stat. 2187.

[40] Maroney-Mayeske Interview.

[41] U.S., Department of Health, Education, and Welfare, Office of Education, Bureau of Occupational and Adult Education, *Trends In Vocational Education, Fiscal Year 1974*, pp 1–2.

[42] Dr. Boyer Testimony, *Washington, D.C. Hearing*, p. 123.

For that same year the mean age of all applicants was 23.8, which was about 1 year older than the mean ages of those accepted to medical schools—22.5 for men and 22.8 for women.[44]

The handbook of *Medical School Admission Requirements*, which is designed to provide medical school applicants with information on opportunities for admission, states:

> Age can be a limiting factor in gaining admission to medical school—so much so that older premedical students should consider carefully before continuing in their educational preparation for medicine.[45]

In a statement submitted to the Commission, the Association of American Medical Colleges included the data presented in table 5.6 on the acceptance rates of applicants by age to the 1976–77 entering class. Less than 3 percent of all applicants and about 1 percent of all those accepted were over the age of 31.[46] Similar representations have been reported every year since the 1971–72 entering class.[47]

Selection criteria reported in the *Medical School Admission Requirements* handbook for 1977–78 for 114 medical schools were reviewed. According to the Association of American Medical Colleges, schools "provide as much information as possible" in their handbook sections so that the applicants "may judge their competitive opportunities."[48] Of the 114 schools, 5 (4.4 percent) stated that age is not a factor considered for admissions; 2 (1.8 percent) indicated that no age limit had been established; 48 (42.1 percent) made no mention of age as part of their selection factors; and 32 (28.1 percent) listed the mean age and/or age range of previously admitted students. The selection criteria specified for 27 schools (23.7 percent) indicated that age was considered in the selection process. The criteria were stated as either the upper age of most applicants who are accepted to the school, the preferred age of applicants, or the upper

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[43] Association of American Medical Colleges, *The Medical School Admission Requirements—1977–78*, p. 15. (hereafter cited as *Admission Requirements*).

[44] W. F. Dube and Davis G. Johnson, Ph.D., "Study of U.S. Medical School Applicants, 1974–75," *Journal of Medical Education*, vol. 51, November 1976, p. 881 (hereafter cited as *Applicants, 1974–75*).

[45] *Admission Requirements*, p. 15.

[46] Dr. John F. Sherman, Association of American Medical Colleges, statement submitted to the U.S. Commission on Civil Rights, *Washington, D.C. Hearing*, vol. II.

[47] Dube and Johnson, *Applicants, 1974–75* ; W. F. Dube and Davis G. Johnson, Ph.D., "Study of U.S. Medical School Applicants, 1973–74", *Journal of Medical Education*, vol. 50, November 1975; W. F. Dube and Davis G. Johnson, Ph.D., "Study of U.S. Medical School Applicants, 1972–73", *Journal of Medical Education*, vol. 49, September 1974; W. F. Dube, Davis G. Johnson, Ph.D., and Bonnie C. Nelson, "Study of U.S. Medical School Applicants, 1971–72", *Journal of Medical Education*, vol. 48, May 1973. Data from these articles report the percentage of applicants and acceptees over the age of 31 for each of the years as follows: 1974–75, 2.4 percent of applicants and 1.0 percent of acceptees; 1973–74, 2.7 percent of applicants and 1.2 percent of acceptees; 1972–73, 3.1 percent of applicants and 1.4 percent of acceptees; and 1971–72, 2.7 percent of applicants and 1.3 percent of acceptees.

[48] Dr. Sherman Statement, *Washington, D.C. Hearing*, vol. II.

Table 5.6
Acceptance Rates of Medical School Applicants by Age, 1966-77, First Year Class

Age[a, b]	Number of Applicants	Percent of all Applicants	Number Accepted	Percent of all Persons Accepted	Acceptance Rates[c]
Under 21	965	2.3	609	3.9	63.1
21-23	25,441	60.4	11,214	71.1	44.1
24-27	11,153	26.5	2,939	18.6	26.4
28-31	3,376	8.0	803	5.1	23.8
32-37	982	2.3	187	1.2	19.0
38+	188	.4	21	.1	11.2
Unknown	50	.1	1	.0	2.0
Total	42,155	100.0	15,774	100.0	37.4
Mean Age	24.2		23.0		

[a] As of September 1976

[b] The oldest male applicant was 53, and the oldest male accepted was 47. The oldest female applicant was 51, and the oldest female accepted was 45.

[c] Acceptance rate is the number of persons in an age group accepted divided by the number of applicants in that age group.

Source: Association of American Medical Colleges, Statement Submitted to the U.S. Commission on Civil Rights, October 28, 1977, p. 6.

Table 5.7
Science Grade Point Averages and Average Science Medical College Admissions Tests Scores of Medical School Applicants by Age, 1976-77

Age[a]	Number of Applicants	Science Grade Point Averages	Med. Col. Admissions Test Scores
22	5,819	3.17	572
26	1,385	3.00	556
30	272	2.92	542
Over 30	889	2.89	533

[a] The data presented by the Association of American Medical Colleges did not include scores for all ages but used only these three specific ages and one group to illustrate that scores decline as age increases.

Source: Association of American Medical Colleges, Statement Submitted to the U.S. Commission on Civil Rights, October 28, 1977, p. 7.

Table 5.8
Science Grade Point Averages and Average Science Medical College Admissions Tests Scores of Applicants Accepted by Medical Schools by Age, 1976-77

Age	Number of Applicants Accepted	Science GPA	Science MCAT
22	1,873	3.39	609
26	379	3.29	612
30	68	3.31	615
Over 30	174	3.25	602

Source: Association of American Medical Colleges, Statement Submitted to the U.S. Commission on Civil Rights, October 28, 1977, p. 8.

age of applicants who are rarely considered for admission.[49]

In its field work and public hearings, the Commission heard from a number of individuals who differed on the extent to which age criteria were employed in the admissions process.

Dr. August Swanson, director of the Department of Academic Affairs of the Association of American Medical Colleges, testified that the age-related statements in the handbook do "not reflect policy but [are] simply informing medical school applicants that there are a variety of factors taken into account in the selection of students for medical school, some of which may be age-related, rather than absolute chronological age."[50] He stated that medical schools began publishing information on selection factors in 1973 because of the rapidly rising numbers of medical school applicants. The schools believed it necessary to provide such information about the characteristics of the admissions system in order to point out clearly students' chances of being accepted. Dr. Swanson indicated that "age was used as a surrogate bit of information to sort of demonstrate the total picture of medical school admissions outcomes," but that chronological age, in his view, is not used as an absolute reason for not considering an applicant's credentials."[51]

At 15 medical schools officials who were interviewed by Commission staff stated in general that age must be considered as a factor in admissions, but that there should be no arbitrary age cutoff, so that officials may make special selections of medical students based on a variety of factors.

A review of catalogs and information bulletins of the schools by Commission staff indicated a more serious treatment of age. For example, the information bulletin of the University of Florida College of Medicine contained an absolute upper age cutoff policy for accepting applications. This policy states that "applicants over the age of thirty rarely will be considered. No applications from persons over thirty-five will be accepted."[52] The *Admission Requirements* handbook cited no age restrictions but listed an age range of 19 to 33 and a mean age of 22.8 for students accepted for the 1975 entering class.[53]

The associate dean for medical education at the Medical College of Pennsylvania said that the institution prefers not to use an upper age limit and that admission of students is based on an inclusive appraisal of both the intellectual and personal qualities deemed necessary for a successful career in medicine.[54] A review of their catalog showed that it contains a policy of nondiscrimination based on age, sex, race, creed, color, or national origin.[55] However, its section in the *Medical School Admission Requirements* handbook includes the statement that "students over age 30 will be seriously considered only when their interim experience will contribute to their professional goal and give them a unique role in medicine."[56]

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[49] *Admission Requirements*, pp. 81–309. One school that specifies an age cutoff in its information bulletin lists only the age range of the 1975 entering class in the handbook, not the age restriction.

[50] Dr. August Swanson Testimony, *Washington, D.C. Hearing*, pp. 342–43.

[51] Ibid.

[52] College of Medicine, University of Florida, "Preliminary Application Information," (Gainesville, undated).

[53] *Admission Requirements*, p. 119.

[54] Medical College of Pennsylvania, interview in Philadelphia, Pa., July 29, 1977. In the interview the associate dean stated that the institution prefers not to use an upper age limit because of non-quantitative factors that should be considered. Some older students are unusually talented (many come from some area of the health field) and have outstanding personal attributes.

The assistant dean of the College of Allied Health Professions at Temple University stated that his institution probably pays less attention to age than do most other medical schools. The institution has had good experiences with older students, he said, because of the diverse life experiences and maturity that an older student brings to the institution. He indicated that what the older applicant has done prior to applying to medical school is important; however, he pointed out that "the older you are, the better you have to be" because of (1) the overwhelming number of applicants from well qualified recent college graduates and the limited number of available places; (2) the length of training; and (3) the length of career (which is expected to be shorter for older students).[57]

The dean of admissions of the Johns Hopkins University School of Medicine pointed out that age can be a problem for the very young applicant as well as the older applicant. This has not presented a problem, officials said, because the institution "attracts younger traditional age students of exceptional backgrounds because of its outstanding reputation in medicine."[58] According to the *Admission Requirements* handbook, the university's selection criteria state that "the mean age of the entering class was 22; rarely is a student over age 29 accepted."[59]

An official of Howard University said that age is not a factor in admissions;[60] however, the school's *Admission Requirements* handbook selection criteria state that "preference is given to applicants who are less than 28 years old. Chances of acceptance are unfavorable for candidates above 30."[61] When questioned about this policy, the official responded that it was established primarily because it was thought that the strenuousness of medical education—the long hours of rigorous curriculum—required younger persons. According to the official, the medical school has never strictly adhered to this policy.[62]

The dean of the University of Maryland School of Medicine stated that his institution has not been confronted with the problem of age, because most applicants apply after or during their third or fourth year in college. Only two or three students are over age 30 by the time they are admitted.[63] While the institution has no specific upper age cut-off, the *Admission*

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[55] The Medical College of Pennsylvania, *Bulletin 1976–78*, p. 28.

[56] *Admission Requirements*, p. 258.

[57] Temple University, interview in Philadelphia, Pa., June 25, 1977 (hereafter cited as Temple University Interview).

[58] Johns Hopkins University, interview in Baltimore, Md., July 12, 1977.

[59] *Admission Requirements*, p. 161.

[60] Howard University, interview in Washington, D.C., July 18, 1977 (hereafter cited as Howard University Interview).

[61] *Admission Requirements*, p. 117.

[62] Howard University Interview.

[63] University of Maryland, interview in Baltimore, Md., July 11, 1977 (herafter cited as University of

Requirements handbook includes this statement: "applicants over the age of 30 cannot be encouraged to apply."[64]

Dr. Chauncey Leake, of the University of California Medical School in San Francisco, testified that admission to his medical school is based on merit without discrimination of any kind. Asked whether the age of the applicant may be taken into account in the admissions process, he responded that the school generally tried to get individuals who are stable:

> . . .we don't want them too young or we don't want them too old. . .we take into account their physical condition, their general mental capacity, and their ability to become useful and helpful members of the health professions.[65]

He clarified this statement by saying that there is no arbitrary chronological age at which the individual is considered too old or too young. Rather, this depends on the admissions committee's judgment of the individual's ability. He also stated that in light of the length of training required to become a physician, it is not wise to enter medical school too late because of the relatively short time that an older student would have to practice medicine.[66]

Dr. John Steward, chairman of admissions at the Stanford University School of Medicine, testified that the environment has existed which conveys to the 30-, 40-, or 50-year-old person that he or she is too old to begin medical school. In fact, he said, the conveyence of that impression has "been rather impressive."[67]

Dr. Harry Ward, dean of the Colorado School of Medicine testified that applicants over the age of 28 have as likely a chance of being accepted to the school as those under age 28. Applicants at age 38 or 39, however, would have a lesser chance of admission because of the age they would be upon completion of training.[68] In an interview with Commission staff, representatives of the school indicated that the average age of applicants has been increasing over the past few years, and that age might be considered during the selection process when dealing with applications of persons in their mid-thirties or older. The reasons given for this concerned age in the context of the potential length of practice compared to the length of training and investment.[69] The *Admission Requirements* handbook reports with regard to the Colorado School of Medicine that nonminority members of the 1975 entering class had an age range of 21 to 37; the mean age was 24.1, and 51 percent of the students were under the age of 24.[70]

Maryland (Baltimore) Interview).

[64] *Admission Requirements*, p. 162.

[65] Dr. Chauncey Leake, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27–28, 1977, vol. I, p. 255 (hereafter cited as *San Francisco Hearing*).

[66] Ibid., pp. 255–56.

[67] Dr. John Steward testimony, *San Francisco Hearing*, p. 261.

[68] Dr. Harry Ward, testimony, *Hearing Before the U.S. Commission on Civil Rights, Denver Colorado*, July 28–29, 1977, vol. I, p. 173 (hereafter cited as *Denver Hearing*).

[69] University of Colorado Medical Center, interview in Denver, Colo., July 7, 1977 (hereafter cited as Colorado Medical Center Interview).

[70] *Admission Requirements*, pp. 106–07.

The University of Colorado School of Medicine also administers a 3-year child health associate program to train individuals to work with pediatricians in providing primary health care. Upon completion of the program, students take an examination and are certified by the State. According to the director of the program, graduates are able to perform approximately 90 to 95 percent of the functions that pediatricians conduct in the care of newborn infants. Of approximately 250 applicants, 20 are accepted into the program each year. The age range is 20 to 44, with 30 percent of the students over age 28.[71]

The director of the child health associate program stated that efforts are made to accept older students into the program because of the school's interest in providing health care in underserved and ghetto areas and around central city and rural areas and the fact that older students in the school's experience are more likely to go into these areas. Other reasons he gave for accepting older students, and older women in particular, is that the variety of experience they often have is beneficial to other students[72] and that older applicants do very well in the program. Age has therefore become a positive factor in the admissions process.[73]

Representatives of three other medical schools stated that applicants should be considered individually and that older applicants are being considered more favorably.[74] The *Admission Requirements* handbook section for one of these institutions, Hahnemann Medical College in Philadelphia, stated that the age range of the 1975 entering class had been 19 to 31 and that "few students were over 30."[75] Also, according to the handbook, the 1975 entering class at another of these institutions, the Medical College of Virginia, Virginia Commonwealth University, had an age range from 18 to 31 with an average age of 21.[76] No age factors were listed in the handbook for the third school.[77]

The academic dean of George Washington University's School of Medicine indicated that the medical school must consider age when reviewing applicants because of the length of training and the financial investment compared to the potential length of practice.[78] The school's section in the *Admission Requirements* handbook states: "Although there are no age limits, very young and relatively older applicants must demonstrate considerable strength in other aspects of their application."[79]

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[71] Dr. Henry Silver, director, Child Health Associate Program, professor of pediatrics and associate dean of admissions, School of Medicine, University of Colorado Medical Center, testimony, *Denver Hearing*, p. 175.

[72] Ibid.

[73] Colorado Medical Center Interview.

[74] Hahnemann Medical College, interview in Philadelphia, Pa., June 27, 1977; University of Pennsylvania, interview in Philadelphia, Pa., June 17, 1977 (hereafter cited as University of Pennsylvania Interview); and Virginia Commonwealth University, interview in Richmond, Va., July 14, 1977 (hereafter cited as Virginia Commonwealth University Interview); Colorado Medical Center Interview.

[75] *Admission Requirements*, pp. 254–55.

[76] Ibid., p. 298.

[77] Ibid., pp. 262–63.

[78] George Washington University, interview in Washington, D.C., June 21, 1977 (hereafter cited as George Washington University Interview).

[79] *Admission Requirements*, p. 114.

In light of the emphasis that is placed on age in admission to medical schools and on the notion of productivity and career length, information was reviewed about the relationship of age to other admissions criteria and to academic success to determine whether the use of age as an admission criterion is based solely on the chronological age of an individual or if it is based on proven differences in the ability and intellectual achievement of persons of varying ages.

According to a statement of the Association of American Medical Colleges, "older applicants, on the average, have lesser essential academic credentials than do younger applicants."[80] For example, data on the 1976–77 entering class (table 5.7) show that younger applicants obtained higher science grade point averages and science scores on the Medical College Admissions Test than did older applicants. Science performance is considered a strong indicator of the applicant's ability to complete a medical school's basic science curricula.[81] The Association of American Medical Colleges data further show that older applicants who were accepted had credentials that were equivalent to those of younger applicants, while those who were rejected had credentials lower than those of younger rejected applicants.[82] (See tables 5.8 and 5.9).

The association offered data which indicate that once accepted to a medical school, older applicants tend to withdraw more often than younger ones[83] (See table 5.10). They claim that this indicates a lack of motivation necessary for completion of medical training:

> If motivation is related to firmness of purpose to go forward with the intent to attend medical school, data demonstrate that older applicants are more likely to change their minds and withdraw after having been accepted.[84]

The association further explained the lower acceptance rates for older applicants by the fact that they file fewer applications than younger applicants. Data indicate that those who file fewer applications are less likely to gain admission to any school.[85] Still another reason offered is that a high proportion of older applicants are "repeaters." The association stated that repeaters present their credentials in competition with each year's new group of college graduates, often with no additional significant accomplishments but with an additional year added to their life history.[86] The association indicated that the fact that older students have a longer life history on which to be judged affects admissions decisions. Although their record of accomplishment can be a positive factor, records sometimes weigh against them because a late decision to enter medicine may be based on economic motivation, a lack of satisfaction with their first career choice, or failure to succeed in a career.[87]

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[80] Dr. Sherman Statement, *Washington, D.C., Hearing*, vol. II.
[81] Ibid.
[82] Ibid., pp. 7–8, see tables A–1 and A–2, appendix.
[83] Ibid., p. 10, see table A–3, appendix.
[84] Ibid., p. 9.
[85] Ibid., pp. 10–11.
[86] Ibid., p. 11.
[87] Ibid., p. 10.

Table 5.9

Science Grade Point Averages and Average Science Medical College Admissions Tests Scores of Applicants Rejected by Medical Schools by Age, 1976-77

Age	Number of Applicants Rejected	Science GPA	Science MCAT
22	2,596	3.07	553
24	634	2.88	535
30	128	2.77	516
Over 30	511	2.83	516

Source: Association of American Medical Colleges, Statement Submitted to U.S. Commission on Civil Rights, October 28, 1977, p. 8.

Table 5.10

Withdrawal Rates for Those Accepted to Medical School by Age, 1976-77

Age	Accepted	Withdrew	Withdrawal Rate
22	1,887	62	3%
26	382	18	5
30	71	4	6
Over 30	176	15	8

Source: Association of American Medical Colleges, Statement Submitted to the U.S. Commission on Civil Rights, October 28, 1977, p. 10.

The association added that a reason for discouraging applications from older applicants is that medical education generally requires from 7 to 10 years of expensive training. Thus, "the investment by society in educating physicians is so great that the proportional reduction in practicing years makes older candidates a less worthwhile societal investment."[88]

Available data on information from the Commission's field study and public hearings indicate that many medical schools use chronological age as a criterion in admissions decisions. The evidence provided by medical school officials and the Association of American Medical Colleges seems to indicate that it is difficult, if not impossible, for applicants over age 27 to enter medical school. Although the data prepared by the association show a slight relationship between the age of applicants and their academic credentials, the most common explanations for giving preference to younger applicants are based on several basic assumptions concerning medical education. For example, the most frequently cited reason for selecting much higher proportions of younger rather than older applicants was that younger applicants have more years of potential practice. Other reasons included: (1) the length of training; (2) the dropout rate of applicants, which increases with age; and (3) the high cost of medical education. These seem to be the primary reasons offered for not accepting older applicants into medical schools.

Admission to Graduate Schools and Law Schools

In examining post-baccalaureate schools other than medicine, the Commission staff were told that applicants within particular age groups may encounter difficulties in gaining admission to some disciplines. Commission staff were informed of cases at three institutions where applicants of certain ages are discouraged from applying or are denied admission because of such factors as career length, job opportunities, and productivity. Admission to other graduate schools and law schools was found to be favorable for older students, up to certain ages.

The dean of the George Washington University School of Government and Business stated that his school deliberately discriminated on the basis of age during the past 2 or 3 years because too many applications were being received from persons over the age of 40. According to the dean, 4 years ago the average age of students had reached 37 and a fraction. After employing an age factor in the admissions process, the average age decreased to 31 or 32. The dean said further that this practice was necessary because the school did not want a reputation of catering to an older student population. It wanted a better mix of ages and academic backgrounds, and it wanted students who had definite career objectives rather than those who wanted "a piece of paper" for promotions.[89] The dean also explained that the school is reluctant to take older women into the master of arts program in health care administration. He defined older women as over 30. He explained that there are difficulties in placing the older woman in the required 1 year residency and in employment. Such applicants are told that although they meet the qualifications for admission, there are no career opportunities for them in the field because of their age.[90]

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[88] Ibid., p. 12.

[89] George Washington University Interview.

At the University of Colorado, Boulder, College of Business and Administration, age distinctions were made between master's and doctoral degree students. While age was not a consideration for admission to the master's program, it was reported as a significant factor in selecting among doctoral applicants. The dean of the college stated that the doctoral program has a bias against applicants over age 35 because of a belief that by the time these applicants obtain degrees they would have a relatively short period of time in which to contribute to the field.[91]

Another limitation on participation of older students in graduate programs in business was offered at Drexel University. The dean of the College of Business and Administration claimed that certified public accounting firms are reluctant to hire individuals over the age of 30. The dean further explained that such firms expect students to have graduated by the age of 27 and to be ready to become a manager or partner by the age of 30. Employers view age 27 or 28 as too old to begin preparing for positions in this area, he said.[92]

The Graduate School of Library Science at Drexel has also considered the age of persons applying to its program. The following statement is included in its admissions requirements:

> While no age limit is set for admission to the School, experience indicates that those who are past 50 and are entering a new field often find that the opportunities for employment open to them are somewhat restricted. For this reason, it is advisable that applicants in this age group discuss career possibilities with the Dean or other members of the faculty before applying for admission.
>
> In keeping with University policy and the American Library Association's *Standards of Accredition, 1972*, admission is open to qualified students regardless of age, race, sex, color, creed, religion, or physical disability.[93]

Officials of various schools at Drexel pointed out that applicants over age 50 are usually counseled regarding job possibilities in their specific field of study. They said that the university informs students about the limited employment possibilities and then lets them decide whether to continue their chosen studies.[94]

Officials at three other institutions stated that they counseled older students when employment opportunities in their selected field were not good because of their age. They all indicated, however, that this was not a reason for not admitting such students and that the students had the right to make their own decisions.[95]

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[90] Ibid.

[91] University of Colorado at Boulder, interview in Boulder, Colo., July 12, 1977 (hereafter cited as University of Colorado (Boulder) Interview).

[92] Drexel University, interview in Philadelphia, Pa., June 23, 1977 (hereafter cited as Drexel University Interview).

[93] Drexel University, *Graduate Bulletin, 1977–1979*, p. 118.

[94] Drexel University Interview.

Officials at two institutions did not agree that age should not influence the selection of students. Both the dean of graduate studies at Stanford University and the dean of the School of Education at the University of Miami testified that age should be used in determining admissions, at least in some instances. When they have limited spaces available for students, they said, they must consider the future productivity of an applicant. It was claimed that older applicants would be expected to work for a shorter period of time after graduation, so they would produce less for the investment made in their education. Both deans claimed that this was a valid consideration that should not be ignored.[96]

It is interesting to note the link drawn between admission to graduate school and job market potential. This is not unlike the situation found in the Comprehensive Employment and Training Act programs and the vocational rehabilitation program. Thus, the behavior of the job market and age discrimination in employment or perceived discrimination appear in some instances to infect the field of education as well.

It was reported to Commission staff that, in general, criteria for admission to graduate programs include not age but the holding of a baccalaureate degree from an accredited institution, an undergraduate grade point average of B or better, acceptable test scores on the graduate record examinations or some other comparable examination, recommendations from previous professors, and, in some cases, personal interviews. According to the executive director of the Council of Graduate Schools, a 1971 survey of approximately 33,000 graduate students at 153 institutions showed that 30 percent of the students were aged 35 or over. He also cited a 1976 study of degree recipients which indicated that close to 30 percent of all doctoral recipients were aged 35 or over.[97]

Being somewhat older than the typical entering graduate student appears to be an advantage for admission to some graduate schools. The average age of students at four of the graduate schools of social work visited by Commission staff was over 25.[98] Over 30 percent of the social work students at the University of Maryland were over the age of 26.[99] The admissions director at the University of Pennsylvania stated that the School of

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[95] University of Pennsylvania Interview; Dr. William Boub, director of continuing education, University of Colorado at Denver, testimony, *Denver Hearing*, p. 168; and Dr. Lou Kleinman, dean, school of education, University of Miami, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida*, Aug. 22–23, 1977, vol I., p. 185 (hereafter cited as *Miami Hearing*).

[96] Dr. Kleinman Testimony, *Miami Hearing*, p. 185; and Dr. Bliss Cornachon Testimony, *San Francisco Hearing*, pp. 262–63.

[97] Dr. John Ryan Testimony, *Washington, D.C., Hearing*, p. 272.

[98] University of Pennsylvania Interview; Virginia Commonwealth University Interview; Howard University Interview; University of Denver, interview in Denver, Colo., July 7, 1977.

[99] University of Maryland (Baltimore) Interview.

Social Work preferred to accept older students, rather than those immediately out of undergraduate school, because of their preference for students who exhibit maturity. This institution considers students in the 25- to 35-year age range as ideal.[100] The dean of the School of Social Work at the University of Maryland stated that, as a matter of policy, the institution encourages students to work 1 or 2 years before entering the graduate social work program, because, in addition to academic preparation, the breadth and quality of life experiences are evaluated in making admissions decisions.[101]

Based on information obtained during the Commission's field study, it appears that experience is becoming an important admission criterion at some law schools. Officials at three law schools stated that age above the usual age when undergraduate school is completed (21 to 22) is a positive factor in the admissions process. Relevant academic and life experiences and exceptional leadership in public service are special admissions factors.[102] According to the director of admissions at Temple University, that school focuses heavily on experience and leadership factors and gives less weight to the law school admissions test than almost all other law schools in the country.[103] The dean at the University of Maryland Law School stated that experience has recently been taken into account in the admission process at his institution, and that, as a result, the age range of students has expanded.[104]

According to a statement submitted by Dr. Millard Ruud, executive director of the Association of American Law Schools, law schools throughout the country are giving preference for admissions to older applicants with several years of interesting work experience over applicants fresh out of undergraduate school. Although work experience is a factor that has a disparate effect on younger age groups, its use, in Dr. Ruud's view, should not be considered discriminatory, since it is justifiable on the grounds of educational policy and of academic performance.[105]

Opportunities For Nontraditional Students

The traditional ages of undergraduate college students are considered to be from 18 to 21 or 22, and graduate studies are traditionally done directly after undergraduate work. In recent years, however, more persons over the age of 22 have been attending institutions of higher education, in part because economic and personal conditions have caused adults over the traditional college age to seek training to enter or re-enter the labor market or to pursue education for personal development.

The age distribution among college students is changing, with the nontraditional age groups representing an increasing proportion of the population. The decrease in the proportion of students who are 18 and 19 years old has been particularly noticeable. Their representation has fallen from 39.5 percent of the college student population in 1965 to 26.4 percent in 1974. During this same period, students aged 25 to 29 have increased from 10.8 percent to 15.1 percent and students 30 to 34, from 5.6 percent to 7.3 percent. In 1974 students 35 or over accounted for 10.4 percent of all college students.[106]

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[100] University of Pennsylvania Interview.

[101] University of Maryland (Baltimore) Interview.

[102] Ibid.; Temple University Interview; University of Pennsylvania Interview.

[103] Temple University Interview.

[104] University of Maryland (Baltimore) Interview.

[105] Dr. Millard Ruud Testimony, *Washington, D.C. Hearing*, pp. 202–06.

The National Advisory Council on Extension and Continuing Education reports that the majority of the current college student population attends on a part-time basis and that one-third of these students are aged 25 to 35. Furthermore, 1 million part-time students are over the age of 35. Seventy-five percent of the total adult part-time student population is employed and, therefore, could not attend or would encounter difficulties in attending on a full-time basis.[107]

Many institutions examined by Commission staff are experiencing the changing age distribution of students and applicants and are responding to the part-time nature of that population out of economic necessity and in response to expressed individual and social needs. As discussed below, some institutions have waived national standardized tests for students beyond a certain age. Some institutions provide students with credit for professional experience or for other types of similar learning experience. Special programs and innovative measures have been initiated in many instances to accommodate the concerns of nontraditional students.

All of the 4-year institutions and all but one of the undergraduate schools or universities visited during the field study require students to take the standardized (SAT or ACT) entrance tests. For the most part, these tests are based on a high school curriculum. Thus, students who have been out of an academic environment for a number of years may encounter difficulties in gaining admission. To account for the problems with the design of these tests, several institutions have waived the tests for students whose high school education may be out of date. For example, one institution has waived the test for students who have been out of high school for more than 3 years.[108] Another institution has waived the test for students who have been out of high school for 10 years or more.[109] A third institution has waived the test for students aged 25 or over.[110] Four institutions reported that they use the test for placement purposes only.[111] Five other institutions have waived the test for students who have been out of high school for several years.[112]

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[106] *The Condition of Education*, p. 226. Data on students 35 years or over were not collected prior to 1973. There is no information provided concerning whether the data have been adjusted to account for this additional age category. The data for the 2 years reported may not be strictly comparable, and the decrease in the 18- and 19-year-olds may actually be less than indicated. Even with the changes in data collected, a decrease for that age group did occur. The report also has data on undergraduate students only. The distribution of undergraduate students 14 to 34 is: 39.6 percent are 14 to 19 years; 29.0 percent are 20 to 24; and 17.3 percent are 25 to 34 years old, p. 227.

[107] *Tenth Annual Report*, pp. 2–3.

[108] Coppin State College, interview in Baltimore, Md., June 24, 1977 (hereafter cited as Coppin State College Interview).

[109] Temple University Interview.

[110] Virginia Commonwealth University Interview.

[111] Coppin State College Interview; George Mason University, interview in Fairfax, Va., June 1977 (hereafter cited as George Mason University Interview); Bowie State College, interview in Bowie, Md., July 19, 1977 (hereafter cited as Bowie State College Interview); and Morgan State University, interview in Baltimore, Md., July 11,

The dean of Swarthmore College stated that standardized tests are inadequate for older students, since they are apt to measure skills that have become rusty, for example, algebra and trigonometry. He supported efforts of the College Board to develop examinations specially designed for older, nontraditional students many years out of an academic setting.[113]

Three junior colleges visited by Commission staff offer older, nontraditional students course credit for experience. These are persons who have worked for a time before beginning or completing their college studies. Credits may be granted for knowledge and skills gained from life experience comparable in scope to learning derived from college level courses. In some cases, proficiency tests can be taken and, if passed, credit earned.[114]

Other schools are also beginnning to take into account skills that are learned through experience. For example, the Graduate School of Engineering at Temple University will award up to 15 credits for experience acquired outside of the school.[115]

Institutions of higher education are also expanding their continuing education programs and providing specially designed programs for nontraditional students. Dr. Richard Francis, of the National Association of Independent Colleges and Universities, reported on such activities conducted by institutions in that association:

> [We] are attempting to provide opportunities outside of what you could call normal school hours. Weekend, special classes. . .in the evenings, special programs which can be completed in briefer periods of time, and these are oriented towards working people who are essentially older than the normal, school-age person.[116]

He further stated that there is considerable interest among the independent institutions to attract nontraditional students in light of the declining number of 18- to 22-year-olds.

The admissions coordinator for the University-Without-Walls Program at Loretto Heights College testified that their program permits students to design their own curriculum with aid from a faculty advisor. Students can use the resources of the institution, other colleges in the area, and the community. Students take classes and obtain credit through jobs, conferences, seminars, independent studies, and internships. The students who

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1977 (hereafter cited as Morgan State University Interview).

[112] Loretto Heights College, interview in Denver, Colo., July 6, 1977; Regis College, interview in Denver, Colo., July 6, 1977 (hereafter cited as Regis College Interview); St. Mary's College of Maryland, interview in St. Mary's City, Md., June 10, 1977; George Mason University Interview; University of Colorado at Denver, interview in Denver, Colo., July 12, 1977 (hereafter cited as University of Colorado (Denver) Interview).

[113] Swarthmore College, interview in Swarthmore, Pa., July 1, 1977.

[114] Peirce Junior College, interview in Philadelphia, Pa., June 22, 1977 (hereafter cited as Peirce Junior College Interview); Regis College Interview; Morgan State University Interview.

[115] Temple University Interview.

[116] Dr. Richard Francis Testimony, *Washington, D.C. Hearing*, p. 363.

are currently in the program range in age from 18 to 65, and the average is 35.[117]

Continuing education programs vary from those that offer only courses for credit to those that offer associate degrees. Most of the universities expressed a strong commitment to continuing, part-time education. At one such institution, officials of the College of General Studies stated that their particular program actually favors older, nontraditional students. An applicant for degree candidacy in the College of General Studies must be at least 21 years of age at the time of filing the application. They said that they believe that their program is unique for older, nontraditional students (22 or over) because it permits such students to obtain a degree, it is less expensive than the regular undergraduate school, and the graduation standards are the same as those for the regular undergraduate school. The student is actually awarded a degree from one of the university's undergraduate colleges.[118]

As stated before, the majority of the current student population is enrolled on a part-time basis. According to the National Advisory Council on Extension and Continuing Education, many part-time students are degree seekers; however, many others have no interest in receiving credits or degrees. Some are professionals or paraprofessionals who need continuing education for new career opportunities. Others seek continuing educational opportunities to prepare themselves for working within their communities.[119]

Based on information obtained during the field study, the public community colleges, in particular, have established programs that tend to attract larger numbers of nontraditional students than do other types of institutions because of their basic mission and the types of programs that are provided. At each of the community colleges visited, from 35 to over 50 percent of the student population were over the age of 25.[120] National data show that over half of the students attending the approximately 1,230 2-year colleges in the country are over age 21, and several community and junior colleges report that the average age of their students is approximately 30. These institutions have 35 percent of the total undergraduate enrollment in the country.[121] According to Dr. Richard Wilson, vice president of the Association of Community and Junior Colleges, "Sixty percent of the community college students are part-time, the average age. . .is now in excess of 30. . . ."[122]

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[117] Pamela Davis Testimony, *Denver Hearing*, pp. 163–64.

[118] University of Pennsylvania Interview; University of Pennsylvania, *The College of General Studies Bulletin*, (1977–78) pp. 9–11.

[119] *Tenth Annual Report*, p. 2.

[120] Community College of Denver, North Campus, interview in Denver, Colo., July 8, 1977 (hereafter cited as Community College of Denver Interview); Dundalk Community College, interview in Dundalk, Md., June 15, 1977 (hereafter cited as Dundalk Community College Interview); Community College of Baltimore, interview in Baltimore, Md., June 24, 1977 (hereafter cited as Community College of Baltimore Interview); Community College of Philadelphia; interview in Philadelphia, Pa., June 22, 1977 (hereafter cited as Community College of Philadelphia Interview); Peirce Junior College Interview, Prince George's Community College, interview in Largo, Md., July 15, 1977 (hereafter cited as Prince George's Community College Interview).

[121] American Association of Community and Junior Colleges, "Students in Two-Year Colleges," a factsheet (May 1977).

College officials reported that nontraditional students are particularly attracted to 2-year public institutions because admission is open and part-time study opportunity is available. At Prince George's Community College in Maryland, officials stated that curriculum expansion into career and technical occupational education in 1971 also contributed to an increase in the median age of the student population.[123] Many new occupational programs were begun in community colleges nationwide during the 1960s.[124] Officials at the Community College of Philadelphia stated that veterans returning from the Vietnam war had increased the median age of its student population. For example, the median age of students had been 19 to 20 before the influx of veterans, and it is now estimated as being 27 to 28.[125]

Professional schools at the University of Maryland have incorporated special programs to assist nontraditional students. The Law School has initiated a part-time day program to assist those students who cannot attend on a full-time basis but also cannot attend part-time night classes because of family responsibilities. The School of Social Work operates an extended master's degree program that can be completed on a part-time basis. A student can take up to 5 years to complete requirements that usually require 2 years.[126]

The Association of State Colleges and Universities reported that in 1974 many schools were instituting special off-campus classes and programs. Such classes are attempts to make education more convenient and available to persons who might not otherwise participate.[127] While the reported programs were for older persons, such classes are also convenient for people who work or have limited time because of family responsibilities.

Some groups of nontraditional students have special problems participating in standard higher education programs. To combat these problems, some colleges and universities have made special efforts aimed at certain target groups. The three predominate groups are "mature women," youth, and older persons.

The University of Colorado at Boulder offers a special program within their continuing education program called the "mini-college" which is aimed primarily at women. It is designed to "be a bridge for mature women over twenty-five returning to school." The mini-college provides extensive testing, counseling, and career and scholastic guidance for approximately 150 participating students, including a few men. The average participant's age is 40.[128] The Association of State Colleges and Universities also reported the beginnings of special counseling and supportive programs for women returning to college.[129]

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[122] Dr. Richard Wilson Testimony, *Washington, D.C. Hearing*, p. 366.

[123] Prince George's Community College Interview.

[124] American Association and Financial Aid of Community and Junior Colleges, "Tuition and Financial Aid in Two-Year Colleges", a factsheet (May 1977).

[125] Community College of Philadelphia Interview.

[126] University of Maryland (Baltimore) Interview.

[127] American Association of State Colleges and Universities *Alternatives for Later Life and Learning: Some Programs Designed for Older Persons at State Colleges and Universities*, (1974) pp. 1–59 (hereafter cited as *Alternatives for Later Life*).

The University of Colorado at Boulder also offers programs for youth below traditional college age with arrangements made on an individual basis for exceptional youth. For example, through such arrangements a 17-year-old had just completed his undergraduate degree. In addition, the school sponsors special summer programs for minority students who have just left high school but not yet entered college, for some high school juniors, and for some junior high school students to try to motivate them to do well in high school in order to attend college.[130] Several other institutions also reported special programs for youth below the normal college entrance age of 18.

Four of the community colleges,[131] three of the 4-year colleges, [132] and seven universities[133] visited by Commission staff offer free, noncredit classes on a space-available basis to all community or State residents aged 60 (or 65), or over. Dr. Harold Delaney of the American Association of State Colleges and Universities reported that a 1974 survey of its 313 member organizations showed that 150 were operating programs of various kinds for persons 60 and over. Many of the institutions offered reduced fees or tuition for the elderly.[134]

An example of a special program for older persons is the noncredit, "living for learning" program at Metropolitan State College in Denver. Part of that program is designed particularly for people over 50. The dean of community services testified that some students who are of "very advanced age" participate at a fraction of the cost of the regular program. Students in this program enroll in classes such as personal growth or legal problems of people who are about to retire or have recently retired. The older students pay about $2 to $4 for a 12-hour sequence that ordinarily costs $25.[135]

Although these types of programs benefit many older persons, they may be age discriminatory. Age is the sole basis for this benefit, which is not available to others who may have the same educational or financial needs but are of a different age.

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[128] University of Colorado (Boulder) Interview.

[129] *Alternatives for Later Life*, pp. 1–59.

[130] University of Colorado (Boulder) Interview.

[131] Community College of Denver Interview; Prince George's Community College Interview; Dundalk Community College Interview; Peirce Junior College Interview.

[132] Peirce Junior College Interview; Regis College Interview; and St. John's College, interview in Annapolis, Md., June 15, 1977.

[133] Morgan State University Interview; Bowie State College Interview; Coppin State College Interview; George Mason University Interview; University of Baltimore, interview in Baltimore, Md., June 14, 1977; Virginia Commonwealth University Interview; University of Colorado (Boulder) Interview.

[134] Dr. Harold Delaney, Testimony, *Washington, D.C. Hearing*, p. 364; and *Alternatives for Later Life*, pp. 1–59.

[135] Dr. Alan Dahons Testimony, *Denver Hearing*, p. 163.

Chapter 6

Food Stamp Program

The food stamp program, authorized by the Food Stamp Act of 1964,[1] was established to "permit low-income households to purchase a nutritionally adequate diet through normal channels of trade."[2] Households meeting specific eligibility criteria—whose members receive cash assistance under the aid to families with dependent children or the supplemental security income programs or whose members' income and resources meet the criteria established for the program—are eligible to purchase food coupons, called "food stamps."[3] These stamps, which have a greater market value than the price eligible households pay for them, may then be used to purchase food in retail food stores approved for receipt of coupons by the Department of Agriculture.[4]

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[1] Food Stamp Act of 1964, Pub. L. No. 88-525, 78 Stat. 703 [codified at 7 U.S.C. §§2011-2026 (1976)]. The Food Stamp Act of 1977, Pub. L. 95-113, 91 Stat. 958, replacing the Food Stamp Act of 1964, was enacted into law on Sept. 29, 1977. This paper addresses the food stamp program as it operated under the Food Stamp Act of 1964, as amended. In its comments on a draft of this chapter, the Department of Agriculture pointed out some of the provisions of the 1977 act that will affect older persons, among others:

> . . .Several provisions will improve access to food stamp benefits for the elderly, blind and disabled. SSI recipients will:
>
> a. Continue to be exempted from the work registration requirement (the exemption age was lowered from 65 to 60 years);
>
> b. Be able to apply for food stamps at the Social Security Office at the same time that application is made for SSI. Information collected as part of the SSI application would be used to help determine eligibility for food stamps;
>
> c. Be informed by the State of food stamp eligibility requirements, rules and benefits;
>
> d. Be required to satisfy the same eligibility standards as all other food stamp recipients (the exemption from the income and resource limits will be removed);
>
> e. Remain ineligible for food stamps in the two food stamp "cashout" States—California and Massachusetts. (SSI recipients in these two States received a larger SSI benefit instead of food stamps.)
>
> f. Elderly persons (60 years of age or older) and their spouses will continue to be able to use stamps to pay for meals served by private establishments (including restaurants) which contract to offer meals for elderly persons at concessional prices. They will also be able to use stamps at public or private non-profit establishments such as senior citizens' center and apartment buildings and at schools that feed senior citizens. (The requirement that meals be served during special hours will be removed, and meals may then be served during regular hours.)
>
> In addition, all elderly and disabled persons, regardless of age, will be able to use stamps to purchase meals from authorized home meal delivery services, and an experimental project is authorized under the new law to see whether it would be desirable to provide a check instead of food stamps to eligible households consisting entirely of members who are entitled to SSI or are age 65 or older.

Joseph E. Shepherd, Acting Deputy Administrator for Family Nutrition Programs, Food and Nutrition Service, U.S. Department of Agriculture, letter to Sherry Hiemstra, Apr. 7, 1978, U.S. Commission on Civil Rights files, (hereafter cited as Shepherd Letter).

Because major changes in the food stamp law were being considered at the time of the Commission's study, only one aspect of the program, outreach, was reviewed. The Commission found that although some geographic areas were not carrying out a full outreach program as mandated by law and regulations, most of the areas were doing so. It was not possible to measure the full effect of the outreach efforts, but program administrators said that outreach was necessary to overcome barriers to participation, such as the complexity of eligibility determination or individuals' pride that existed with respect to the program.

Program Description

The purpose of the food stamp program is twofold—to alleviate hunger and malnutrition among members of low-income households, and to promote the distribution of agricultural surpluses and strengthen the agricultural economy.[5]

When the program was first implemented, State participation was optional. However, the act also provided that in areas where a food stamp program was in effect no distribution of federally donated food commodities would be permitted except in emergencies, as defined by the Secretary of Agriculture.[6] The 1971 amendments to the act, while retaining the language of the original law, added a proviso allowing for distribution of food at the request of the State agency.[7] This "dual distribution" method has usually been permitted in emergencies or while

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[2] 7 U.S.C. §2011 (1976).

[3] 7 U.S.C. §2014(a) (1976) and 7 C.F.R. §§271.3(b) and (c), 270.1(v) (1976). Recipients of Supplemental Security Income (SSI) in States that have elected to provide a cash payment rather than food stamps to SSI recipients are not eligible. Two States "cash out" their food stamp program: California and Massachusetts.

[4] 7 U.S.C. §2013(a) (1976).

[5] 7 U.S.C. §2011 (1976).

[6] Food Stamp Act of 1964, Pub. L. No. 88-525, §4(b), 78 Stat. 704.

[7] Food Stamp Act Amendments, Pub. L. No. 91-671, §3, 84 Stat. 2049 (1971) [codified at 7 U.S.C. §2013(b) (1976)].

States were making the transition to food stamps.[8]

States had set their own eligibility rules for the program, generally in line with the eligibility standards set for the cash assistance programs of the particular State.[9] In 1971, however, amendments to the Food Stamp Act required the Secretary of Agriculture, in consultation with the Secretary of Health, Education, and Welfare, to establish uniform national standards of eligibility for participation in the program.[10] The 1973 amendments provided for phasing out the food-distribution program and called for implementation of the food stamp program in all areas of the country no later than June 30, 1974.[11]

The food stamp program is administered at the Federal level by the Department of Agriculture. The agency responsible for the program at the State level is the agency that administers cash assistance programs, which include cash assistance supported in whole or in part by the State to persons who receive aid to families with dependent children under the Social Security Act, general cash assistance, and, in some States, cash assistance as a supplemental payment to aged, blind, or disabled persons receiving supplemental security income under the Social Security Act.[12] These State agencies are generally referred to as welfare departments, departments of public aid, or departments of human resources. They are responsible for certifying households eligible for food stamps; for issuing coupons to those households that are eligible; for receiving, storing, and protecting coupons delivered to the State; and for control and accounting of coupons.[13] The 1971 amendments to the act require that the State agency "shall undertake effective action. . .to inform low-income households concerning the availability and benefits of the food stamp program and insure the participation of eligible households."[14] This activity has been defined by the Department of Agriculture as "outreach," and includes providing "reasonable and convenient access to the program" and "taking into consideration the special needs of, among others, the elderly, the disabled, migrants, persons residing in rural areas, and ethnic groups."[15]

The Food Stamp Act, as originally enacted, provided that the Federal Government would be responsible for the cost of the food stamps themselves, the administrative costs of making the stamps available to the States, and 50 percent of certain State costs of administering the program for non-welfare households, including salary, fringe benefits, and travel costs related to certification of non-public assistance households and field investigation of applicant non-public assistance households. States were required to assume 100 percent of other costs, such as the cost of issuing food stamps to eligible households.[16] The 1971 amendments provided for a Federal cost-sharing rate of 62.5 percent instead of 50 percent.[17] In addition, outreach costs were added to the activities permitted to be financed in part with Federal funds.[18] The 1974 amendments returned the Federal matching rate for administrative costs to the original figure of 50 percent.[19] The entire benefit cost of the food stamp program continued to be borne by the Federal Government, which paid the full bonus cost of stamps by redeeming them for 100 percent of their face value.[20]

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[8] U.S., Congress, House, Committee on Agriculture, *Food Stamp Act of 1977 : Report*, 95th Cong., 1st sess., 1977, H. Rept. 464, p. 297 (hereafter cited as *Food Stamp Report*).

[9] Food Stamp Act of 1964, Pub. L. No. 88–525, §5(b), 78 Stat. 704.

[10] Food Stamp Act Amendments, Pub. L. No. 91–671, §4(b), 84 Stat. 2049 [1971) (codified at 7 U.S.C. §2019(e)(8) (1976)].

[11] Act of Aug. 10, 1973, Pub. L. No. 93–86, §3(i), 87 Stat. 247, 248 [codified at 7 U.S.C. §2019(e)(8) (1976)].

[12] 7 C.F.R. §270.2(vv) (1976).

[13] U.S.C. §§2015, 2019(b) (1976).

[14] 7 U.S.C. §2019(e) (1976).

[15] 7 C.F.R. §271.(k) (1976).

To be eligible for food stamps, persons must be members of "households whose income and other financial resources are determined to be substantial limiting factors in permitting them to purchase a nutritionally adequate diet," as defined by the Secretary of Agriculture.[21] The cost of a nutritionally adequate diet has been estimated by the Department of Agriculture to be the amount necessary to purchase foods that would comprise a "Thrifty Food Plan"—the least costly of four plans developed by the Department.[22] This plan estimates the cost of a family's diet according to the number and ages of men, women, and children in the family, and is the basis for setting the coupon allotment for the food stamp program.[23]

Low-income households that would be eligible for the food stamp program have been defined as: (1) households in which all members are included in a public assistance grant or general assistance grant, without regard to the income and resources of the household members, or (2) households that meet the income and resource requirements of the program.[24] To meet the income requirements, households have been required to have incomes below the poverty level or below the level at which the coupon allotment for which they were eligible equaled 30 percent of their income.[25] A household has been defined in the statute as "a group of related individuals (including legally adopted children and legally assigned foster children) or non-related individuals over age 60 who are not residents of an institution or boarding house, but are living as one economic unit sharing common cooking facilities and for whom food is customarily purchased in common. . . ." A household may also be defined as a single individual living alone who has cooking facilities and prepares food for home consumption, persons aged 60 or over and their spouses who use coupons to purchase meals prepared for and delivered to them, or narcotics addicts or alcoholics participating in drug or alcohol rehabilitation treatment programs.[26] In 1973 the "relatedness" requirement in the definition of an eligible

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[16] Food Stamp Act of 1964, Pub. L. No. 88–525, §15(b), 78 Stat. 709.

[17] Food Stamp Act Amendments, Pub. L. No. 91–671, §8(b), 84 Stat. 2052 (1971).

[18] *Id.* [codified at 7 U.S.C. §2024(b) (1970)].

[19] Act of July 12, 1974, Pub. L. No. 93–347, §2(b), 88 Stat. 341 [codified at 7 U.S.C. §2024(b) (1976)].

[20] 7 U.S.C. §2013(a) (1976).

[21] 7 U.S.C. §2014(a) (1976).

[22] 40 Fed. Reg. 55,646, 55,646 (1975).

[23] 41 Fed. Reg. 27, 365 (1976).

[24] 7 C.F.R. §§271.3(b)-(c) (1976).

[25] 7 C.F.R. §271.3(c)(3) (1976).

[26] 7 U.S.C. §2012(e) (1976).

Table 6.1
Maximum Allowable Income Standards for 48 States and the District of Columbia, Effective July 1, 1976

Household Size	Maximum Allowable Monthly Income
One	$245
Two	322
Three	433
Four	553
Five	660
Six	787
Seven	873
Eight	993
Each additional member	+ 127

Source: 41 Fed. Reg. 27,365, 27,365-66 (1976).

household was struck down in *Knowles* v. *Butz* [27]

The maximum allowable income standards for households, effective on July 1, 1976, for 48 States and the District of Columbia (excluding Alaska and Hawaii, which had separate income standards) are presented in table 6.1.

Monthly net income used in these standards is determined by calculating gross income and then taking allowable deductions. Allowable deductions for the food stamp program have included:

- 10 percent of wages or training allowance, not to exceed $30 per household per month;
- mandatory deductions from earned income such as local, State, and Federal income taxes;
- medical payments if they exceed more than $10 per month per household;
- child care or invalid care payments when necessary for a household member to work or participate in training for employment;
- expenses incurred because of disaster or casualty loss which could not be reasonably anticipated by the household;

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[27] Knowles v. Butz, 358 F. Supp. 228 (N.D. Calif. 1973).

- tuition or mandatory educational fees;

- shelter costs in excess of 30 percent of household income after the above deductions, including utilities, rent, mortgage payments, and interest on own home, and property taxes.[28]

To be eligible for food stamps, individuals have also had to meet the resource requirements of the program. Federal regulations provide that "the maximum allowable liquid and non-liquid assets of all members of the household shall not exceed $1,500 for the household, except that for households of two or more persons with a member or members aged 60 or over, such resources shall not exceed $3,000."[29] In determining the value of resources, the following are excluded:

- a home and lot that do not exceed what is normal in the community;

- one car or other licensed vehicle for transportation;

- household goods;

- cash value of life insurance policies and pension funds;

- property producing income consistent with fair market value or needed for employment;

- Indian land held jointly with a tribe or that can be sold only with approval of BIA [Bureau of Indian Affairs];

- resources whose cash value is not accessible to the household, such as irrevocable trusts;

- payments under the Women, Infants, and Children program (WIC) or Title II of the Uniform Relocation Assistance and Real Properties Acquisition Act of 1970.[30]

Persons aged 18 or over may not participate in the food stamp program if they are claimed as dependents for Federal tax purposes by persons who are not members of households eligible for food stamps. Able-bodied adults between 18 and 65 (except mothers, incapacitated adults, students in accredited schools or training programs, or persons working at least 30 hours a week) must register for employment and accept employment or public work if it becomes available.[31]

To receive a food stamp allotment, eligible households have been required to pay a purchase price set by the Department of Agriculture, based on the size of the household and size of monthly net income. Table 6.2 shows the monthly purchase requirements and monthly coupon allotments effective July 1, 1976, for households of varied sizes and incomes.[32]

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[28] 7 C.F.R. §271.3(c)(1)(iii) (1976).

[29] 7 C.F.R. §271.3(c)(4)(i) (1976).

[30] 7 C.F.R. §271.3(c)(4)(iii) (1976).

[31] 7 U.S.C. §§2014(b)-(c) (1976).

To participate, members of a household must go to an office of the agency administering the food stamp program (generally located in each county), provide documentation of the income of the household, and complete an application. If the household is found eligible, it is issued an authorization to purchase (ATP) card which shows the face value of the coupon allotment and the amount to be paid by the household for such allotment.[33] A member of the household must then take this card to one of the points established by the State or local agency where stamps can be purchased, such as a post office or bank.[34] Household members may use the stamps in retail food establishments authorized to accept the coupons.[35] As a result of the 1971 amendments to the act, members of an eligible household who are 60 or over, or a person 60 or over and his or her spouse, may use the food stamps to purchase meals prepared and delivered by public or private nonprofit agencies, provided the recipients are housebound, feeble, physically handicapped, or otherwise disabled to the extent that they are unable to adequately prepare all of their meals.[36] Persons 60 or over and their spouses may also use coupons to purchase meals prepared in congregate meal sites, such as senior citizens' centers, apartment buildings occupied primarily by older persons, public or nonprofit private schools, and any other organization that has a contract with the State to provide meals for older persons.[37]

Other provisions have been included in the food stamp law that treat persons 60 or over differently from other individuals or households. In summary, the provisions provide that:

- "Household" is defined as a group of individuals 60 or over who are not residents of a boarding house but are living as one economic unit sharing cooking facilities and food;[38]

- Older persons, unlike other persons applying for stamps, are not required to have cooking facilities if they are eligible to participate in a home-delivered meals program or in a congregate-housing meals program;[39]

- Persons 65 or over who have applied for food stamps are not required to register for work;[40]

- As stated above, persons 60 or over are allowed a higher level of assets than other applicants. If a household has two or more members one or more of whom is 60

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[32] 41 Fed. Reg. 27,365–66 (1976).

[33] 7 C.F.R. §270.2(e) (1976).

[34] *Food Stamp Report*, p. 309.

[35] 7 U.S.C. §2013(a) (1976).

[36] Food Stamp Act Amendments, Pub. L. No. 91–671, §6[c), 84 Stat. 2051 (1971) [codified at 7 U.S.C. §2019(h) (1976)].

[37] 7 U.S.C. §2019(h) (1976).

[38] 7 U.S.C. §2012(e) (1976). Although the statute includes "related individuals" within the household definition, this "relatedness" requirement was struck down in 1973 by Knowles v. Butz, 358 F. Supp. 228 (N.D. Calif. 1973).

[39] *Id.*

[40] 7 U.S.C. §2014(c) (1976).

Table 6.2

Monthly Coupon Allotments and Purchase Requirements for 48 States and the District of Columbia, Effective July 1, 1976

Monthly net income	For household of—							
	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
	The monthly coupon allotment is—							
	$50	$92	$130	$166	$198	$236	$262	$298
	And the monthly purchase requirement is—							
$0 to $19.99	0	0	0	0	0	0	0	0
$20 to $29.99	1	1	0	0	0	0	0	0
$30 to $39.99	4	4	4	4	5	5	5	5
$40 to $49.99	6	7	7	7	8	8	8	8
$50 to $59.99	8	10	10	10	11	11	12	12
$60 to $69.99	10	12	13	13	14	14	15	16
$70 to $79.99	12	15	16	16	17	17	18	19
$80 to $89.99	14	18	19	19	20	21	21	22
$90 to $99.99	16	21	21	22	23	24	25	26
$100 to $109.99	18	23	24	25	26	27	28	29
$110 to $119.99	21	26	27	28	29	31	32	33
$120 to $129.99	24	29	30	31	33	34	35	36
$130 to $139.99	27	32	33	34	36	37	38	39
$140 to $149.99	30	35	36	37	39	40	41	42
$150 to $169.99	33	38	40	41	42	43	44	45
$170 to $189.99	38	44	46	47	48	49	50	51
$190 to $209.99	38	50	52	53	54	55	56	57
$210 to $229.99	40	56	58	59	60	61	62	63
$230 to $249.99	40	62	64	65	66	67	68	69
$250 to $269.99		68	70	71	72	73	74	75
$270 to $289.99		72	76	77	78	79	80	81
$290 to $309.99		72	82	83	84	85	86	87
$310 to $329.99		72	88	89	90	91	92	93
$330 to $359.99			94	95	96	97	98	39
$360 to $389.99			102	104	105	106	107	108
$390 to $419.99			111	113	114	115	116	117
$420 to $449.99			112	122	123	124	125	126
$450 to $479.99				131	132	133	134	135
$480 to $509.99				140	141	142	143	144
$510 to $539.99				142	150	151	152	153
$540 to $569.99				142	159	160	161	162
$570 to $599.99					168	169	170	171
$600 to $629.99					170	178	179	180
$630 to $659.99					170	187	188	189
$660 to $689.99					170	196	197	198
$690 to $719.99						204	206	207
$720 to $749.99						204	215	216
$750 to $779.99						204	224	225
$780 to $809.99						204	226	234
$810 to $839.99							226	243
$840 to $869.99							226	252
$870 to $899.99							226	258
$900 to $929.99								258
$930 to $959.99								258
$960 to $989.99								258
$990 to $1,019.99								258

Source: 41 Fed. Reg. 27,365, 27,365-66 (1976).

or older, a maximum of $3,000 in assets is allowed. Other applicants have only been able to have $1,500.[41]

State agencies administering the food stamp program are required to provide outreach. The law provides, as a result of the 1971 amendments, that the State agency:

> . . .shall undertake effective action, including the use of services provided by other federally funded agencies and organizations, to inform low-income households concerning the availability and benefits of the food stamp program and insure the participation of eligible households.[42]

The Federal regulations developed pursuant to this mandate provided that the States:

> . . .take effective action pursuant to an approved outreach plan, using State agency personnel and the services provided by federally funded and other agencies and organizations to inform low-income households, with due regard to ethnic groups, of the availability and benefits of the program and encourage the participation of eligible households.[43]

These outreach plans, which were to be submitted annually beginning July 1972, were to include a description of the outreach activities to be undertaken in each State, the monitoring and evaluation procedures to be used to assess State and local outreach efforts, and the timetables for developing and implementing a plan to reach potentially eligible households.[44]

Much controversy has surrounded the question of whether the States were, in fact, implementing the outreach mandate. By the end of 1972, the Department of Agriculture had approved outreach plans in only 32 States.[45] During 1972 and 1973, lawsuits charging that the outreach efforts of the States were not in accordance with instructions of the Department were filed in 22 States. Finally, a Federal suit in Minnesota in June 1973, *Bennett* v. *Butz*, [46] charged, among other things, that the Secretary of Agriculture failed to implement the statutory outreach requirements, and refused to take remedial action after States failed to formulate and implement appropriate outreach plans.[47] As a result of this case, the court ordered the Department to review all State outreach plans and provide remedial action.[48]

The Department published revised regulations in April 1975 in part to respond to the court's decision.[49] The regulations provided that:

> . . .each State agency shall initiate and monitor effective, comprehensive ongoing efforts performed cooperatively with other public and private agencies, religious, business, and civic groups, retail trade associations, unions, community organizations, news media, and other groups, organiza-

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[41] 7 C.F.R. §271.3(c)(4)(i) (1976).
[42] 7 U.S.C. §2019(e)(5) (1976).
[43] 7 C.F.R. §271.1(k) (1975).
[44] 37 Fed. Reg. 1159, 1159 (1972).
[45] Bennett v. Butz, 368 F. Supp. 1059, 1065 (D. Minn. 1974).
[46] *Id.*
[47] *Id.*, at 1062–63.
[48] *Id.*, at 1072
[49] 40 Fed. Reg. 16,069, 16,069 (1975).

> tions, and associations to inform low-income households eligible to receive food stamps of the availability and benefits of the program and to insure the participation of eligible households with reasonable and convenient access to the program. Such efforts. . .shall take into consideration the special needs of, among others, the elderly, the disabled, migrants, persons residing in rural areas, and ethnic groups.[50]

With regard to staffing for the outreach efforts, the regulations provided further that:

> . . .each State agency shall designate one person to serve full-time as State Outreach Coordinator with responsibility to initiate, coordinate, monitor, and evaluate ongoing food stamp outreach action and shall provide such coordinator with clerical and support staff necessary for effective implementation of the outreach program. Each State agency shall provide project area outreach coordinators in accordance with FNS [Food and Nutrition Service] outreach instructions.[51]

Implementing instructions that were developed and issued by the Department elaborated on the provisions of the regulations and provided a listing of the agencies and organizations that the outreach coordinator would be required to contact, including Federal, State, and local governmental agencies; public and private health and medical organizations; church, civic, fraternal, and community groups; business and labor organizations; and stores and groups authorized to accept food stamps.[52]

The States responded affirmatively this time to the requirement to develop outreach plans. By July 1, 1975, all States had submitted outreach plans;[53] however, there is some indication that the plans were not in fact carried out. In response to a questionnaire mailed in late 1975 as part of a food stamp study by the House Committee on Agriculture, the majority of respondents said that "in their areas there was either no outreach effort or very little undertaken by the local food stamp office."[54] State and local administrators contacted as part of the same study "questioned the need for expanded outreach and doubted its efficacy in bringing eligibles into the program." Mainly, however, they saw the outreach activities as "an unreasonable administrative and financial burden on local and State agencies."[55]

As the outreach controversy neared resolution through court action and response by the Department of Agriculture, another issue was raised in the food stamp program—whether the eligibility rules and procedures enabled a wider range of persons to participate than the program was intended to serve, and whether, as a result, it was too costly. Despite a relative lack of outreach, the program had grown from 6.7 million participants in the food stamp and food distribution programs in 1969 to 14.7 million in 1972 and to 19.3 million in April and May of 1975. The cost of the program in fiscal year 1976 was $5.7 billion.[56]

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[50] 7 C.F.R. §271.1(k) (1976).

[51] *Id.*

[52] U.S., Department of Agriculture, Food and Nutrition Services, FNS (FS) Instruction 732, 6 Rev. 1, *State Outreach and Education Activities* (April 1975), appendix A. (hereafter cited as *State Outreach Instructions*).

[53] *Food Stamp Report*, p. 344.

[54] U.S., Congress, House, Committee on Agriculture, *Food Stamp Program,* 94th Cong., 2d sess., 1976, Comm. Print, p. 340 (hereafter cited as *Food Stamp Program*).

[55] Ibid., p. 89.

Critics of the program claimed that this growth was the result of increasingly liberal eligibility requirements that made it easy for people who may not be needy to become eligible.[57] The Chairman of the Senate Select Committee on Nutrition and Human Needs pointed out, however, that much of the growth was the result of the transfer to food stamps of some commodity distribution programs, and that other growth was the result of an economic downturn that the food stamp program had been meant to address and of inflation in food prices.[58] According to the Department of Agriculture, the actual reason for the program growth may have been that a food stamp program was mandated for all geographic areas during the period of the early 1970s.[59] Others argued that many requirements and procedures of the program discouraged persons from participating. Most frequently mentioned in this regard were the requirement that persons use some of their cash to purchase stamps rather than simply receive the stamps; the complexity of determining eligibility because of the income and resource provisions; and the fact that the person using food stamps had to be determined eligible for stamps at one location, purchase stamps at a second location, and use stamps to buy food at a third location.[60]

As a result of the questions raised about the cost of the program, who was participating, and whether procedures presented barriers to participation, a study of the program was conducted by the Congress, and comprehensive food stamps reform legislation was considered throughout 1976 and 1977.[61] For this reason, the Commission restricted its review of the food stamp program to its outreach provisions. This was an area of particular interest because, except for the early and periodic screening, diagnosis, and treatment services under Medicaid, outreach was not a mandated component of any other program that the Commission studied.

Summary of the Record

Program Participants

Scant information on the number and ages of persons eligible to participate in the food stamp program has been available because of the difficulty in estimating the number of persons who meet the program's income and resource requirements. The Department of Agriculture has projected that between 29 and 32 million persons will be eligible for food stamps in fiscal year 1978 and that 5 million of them will be aged 60 or older.[62] Comparable information is not available, however, for the same time for which data on persons actually participating in the program are available.[63] For this reason, comparisons of the ages of persons eligible for the program with the ages of those actually participating cannot be made.

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[56] *Food Stamp Report*, pp. 6–7.

[57] U.S., Congress, Senate, Select Committee on Nutrition and Human Needs, *Who Gets Food Stamps ?* 94th Cong., 1st sess., 1975, Comm. Print, pp. 1–3 and 51–55 (hereafter cited as *Who Gets Food Stamps ?*); Shepherd Letter; *Food Stamp Report*, pp. 2–10.

[58] *Who Gets Food Stamps ?*, p. 1–3.

[59] Shepherd Letter.

[60] *Food Stamp Program*, pp. 359–60.

[61] *Food Stamp Report*, p. 1.

With regard to who participates in the food stamp program, data available on persons identified as participating during the month of September 1976, presented in table 6.3, show that 995,000 persons, or 6.5 percent of all persons participating during the period of the survey, were 65 or older. An additional 7.1 percent were between 50 and 65, and 58.1 percent were under 20.

Information on households participating in the program for the same period by age of male and female heads of households are shown in table 6.4. Again, there is no information available on the number of households, by age of head of household, estimated to be eligible for the program.

Although it is not possible to make age comparisons between participants and eligibles, numerous individuals and organizations have consistently claimed that one age group— persons aged 60 or over— has not participated in the program to the degree expected. In 1973 Frank Carlucci, then Undersecretary of Health, Education, and Welfare, testified before the Senate Select Committee on Nutrition and Human Needs:

> . . .the participation rate [in the food stamp program] for current recipients of the adults [cash] assistance program is low. Of the recipients in the three categories, aged, blind, and disabled, 18 percent receive commodities and 28 percent participate in the Food Stamp program, although all are automatically eligible as public assistance recipients.[64]

In recognition of this limited participation by older persons, the administration launched Project FIND, a door-to-door canvassing effort to contact older persons, inform them about the food stamp program, and assist them to become certified for Federal food assistance. Under this project, the American Red Cross trained volunteers from local communities to find older persons in need of food assistance and tell them about the program.[65]

In late 1975 local community groups were asked, as part of a study on food stamps conducted by the Agriculture Committee of the House of Representatives, to "identify which groups in their area had special problems in applying for and being certified for food stamps." Of the groups questioned, 80 percent identified the elderly. They said that the difficulties the elderly experienced resulted from the stigma attached to food

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[62] Judy Reitman, U.S. Department of Agriculture, telephone interview in Wash., D.C., Mar. 6, 1978.

[63] Ibid.

[64] U.S., Congress, Senate, Select Committee on Nutrition and Human Needs, *Nutrition and the Elderly — 1973 : Hearings, Part 1—Feeding the Elderly*, 93d Cong., 1st sess., 1973, Frank Carlucci, Undersecretary, Department of Health, Education, and Welfare, testimony, p. 10.

[65] Willis Atwell, Administration on Aging, U.S. Department of Health, Education, and Welfare, telephone interview in Wash., D.C., Mar. 7, 1978.

Table 6.3
Distribution of Participating Persons by Age and Selected Characteristics, September 1976

	0-14	15-19	20-34	35-49	50-64	65+	Unknown	Total	Percent
Female Head of Household With Dependent Children	3,446	91,733	1,367,238	636,900	153,278	0	2,375	2,254,973	14.8%
Children Younger Than 21 in Female Headed Households	4,810,993	1,002,300	44,671	0	0	0	0	5,857,966	38.4%
Male Heads of Households With Dependent Children	1,258	12,283	318,491	246,009	79,552	0	0	657,595	4.3%
Children Younger Than 21 in Male Headed Households	1,687,888	368,351	35,147	0	0	0	0	2,091,386	13.7%
Persons Age 65 and Over	0	0	0	0	0	995,685	0	995,685	6.5%
Disabled (Under 65)	1,083	27,873	171,358	262,884	514,104	0	0	977,304	6.4%
All Other Household Members of Age or Disabled Household Heads	572,597	252,012	105,992	97,497	106,550	0	333	1,134,983	7.4%
All Other Participants	12,124	32,748	670,510	336,763	237,412	0	8,822	1,298,473	8.5%
TOTAL	7,089,482	1,787,303	2,713,409	1,580,056	1,090,897	995,685	11,532	15,268,368	100.0%
	(46.4%)	(11.7%)	(17.8%)	(10.3%)	(7.1%)	(6.5%)	(.1%)		

Source: U.S., Department of Agriculture, Food and Nutrition Service, *Characteristics of Food Stamp Households September 1976* (1977), table 57.

stamps, complicated application forms, long waits for appointments and interviews, the small bonus received by many elderly households, ineffective or non-existent outreach for this group, and restrictive resource and asset limitations. Other groups identified as having special problems in applying were the disabled, low-income unemployed persons, and unemployed persons. Recommendations made by these community groups for increasing the participation of older persons included home visits by certification workers, use of authorized representatives to purchase stamps for the elderly, locating the food stamp office somewhere other than the welfare office, and simplification of the application forms and procedures.[66]

In the same study, State and local program administrators were asked to identify which groups, if any, presented administrative problems from a list that included aliens, the disabled, the elderly, Indians, migrants, military, strikers, and students. Thirty-one percent of the administrators cited the elderly and gave the following reasons:

> . . .[their] difficulties in understanding complex food stamp regulations, complying with verification requirements, and completing the detailed forms;. . .difficulties in getting to the food stamp and issuance offices;. . .restrictive resource limita-

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[66] *Food Stamp Program*, pp. 327 and 346–47.

> tions; potential eligibles' antipathy to "welfare"; inability to take advantage of itemized expenditure deductions; purchase requirement increases concomitant with Social Security increases; and, in general, the small bonus available to many elderly households.

To counter these barriers to participation, the administrators recommended that:

> . . .the [application] procedure be simplified for the elderly or that more help be made available to. . .[the elderly] in completing the procedure,. . .[and that there be] longer certification periods, greater use of home visits, telephone interviews, and itinerant offices, and development of community transportation, increased allotments or decreased purchase prices,. . .and better coordination between food stamp and Social Security/SSI benefits.[67]

In April 1977 Senator John Melcher, presiding over a hearing of the Special Committee on Aging of the U.S. Senate, noted that "there are 5 million or more elderly persons [65 or over] who should be considered for food stamps but only about 1 million participate in the food stamp program."[68] The Department of Agriculture's *1976 Survey of Characteristics of Food Stamp Households,* confirm this participation rate (See table 6.3). The survey indicated that a total of 995,685 persons 65 or over, or slightly less than 20 percent of those persons 65 or over who would be eligible, are served by the program.[69]

Assistant Secretary of Agriculture Carol Foreman told the Commission that the participation rate for older persons is lower than the overall average for participation in the program, which she estimated to be 50 percent.[70] She also commented in written testimony on the limited participation of SSI recipients in the food stamp program:

> Because SSI recipients are categorically eligible for food stamps under the current law, we are concerned about their participation. We know there are 3.45 million SSI recipients in this country, excluding those in Massachusetts and California, where SSI households' food stamp benefits are cashed out in the form of a supplement to their SSI checks.
>
> Most, but not all, of these SSI recipients are eligible for food stamps. (Some who live with persons not on SSI may be ineligible if those persons have incomes that place the household over the income eligibility limit.) We know, however, that about 1 million *households* with SSI income are receiving food stamps, and that

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[67] Ibid., pp. 78, 80.

[68] U.S., Congress, Senate, Special Committee on Aging, *Effectiveness of Food Stamps for Older Americans: Hearing, Part 1-Washington, D.C.*, Cong., 1st sess., 1977, p. 2 (hereafter cited as *Food Stamp Effectiveness*).

[69] U.S., Department of Agriculture, Food and Nutrition Services, FNS-168, *Characteristics of Food Stamp Households: September 1976* (1977), table 57 (hereafter cited as *Households Characteristics*).

[70] Carol T. Foreman, Assistant Secretary, Food and Consumer Services, Department of Agriculture, testimony, *Hearing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Sept. 26-28, 1977, vol. I, p. 199 (hereafter cited as *Washington, D.C. Hearing*).

> some of these households contain more than one SSI recipient. Overall, this data indicates that between one-third and one-half of all eligible SSI recipients are receiving food stamps.[71]

The Assistant Secretary attributed the low participation by older persons to a number of factors, including the purchase requirement, the stigma attached to using food stamps (which she stated was particularly true of the elderly), the need to travel long distances to apply for and receive food stamps, and treatment of older persons by staff.[72] She also indicated that to remove these barriers, the Department had proposed new legislation and minimum staffing standards and would "pursue outreach activities."[73]

Thus, in all instances where participation by older persons was identified as a problem, outreach was the means proposed to increase their participation.

Outreach

Whether outreach is effective is difficult to assess because of a myriad of factors, including unemployment and inflation, that influence whether persons participate in the food stamp program. Assistant Secretary Foreman told the Commission that the Department of Agriculture "cannot determine that outreach activities have substantially increased the number of people receiving food stamps."[74] Despite the fact that its impact is difficult to measure, outreach, including a transportation component, has clearly been considered one of the principal tools needed to make persons aware of the program and increase their participation. It has been recommended by Federal, State, and local officials and community groups as the means for bringing eligible persons into the program. In addition, studies have indicated that "one of the major reasons potential eligibles did not participate was because they had incomplete or incorrect information about the program"[75] or that "the need for transportation to distant food stamp issuance points hindered participation by the rural elderly poor."[76] On transportation, one study observed that "it was not the problem of securing transportation just to apply, but the need for transportation on a regular basis to pick up the monthly food stamp allotment which was the prohibiting factor." Most indicated that obtaining transportation would require additional outlays, thus adding to the true cost of participating in the food stamp program.[77]

For these reasons, the extent to which outreach is conducted, the types of outreach that are employed, and the persons to whom outreach is targeted are important considerations in the food stamp program.

Outreach activities in the food stamp program are, as Assistant Secretary Foreman said, "administered largely by the States." She went on to say that "the key to effective outreach is. . .the ability [of the Department of Agriculture] to persuade the States to undertake those activities in a manner that's appropriate." She further indicated that the Department would "go from State to State, asking for verification that an outreach program is adequate."[78]

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[71] Foreman Statement, *Washington, D.C. Hearing*, vol. II.

[72] Foreman Testimony, *Washington, D.C. Hearing*, pp. 198–99.

[73] Ibid., pp. 195–99.

[74] Ibid., p. 195.

[75] *Food Stamp Report*, p. 345.

[76] *Food Stamp Effectiveness*, p. 5.

[77] Ibid., pp. 5–6.

The 1976 study of the House Committee on Agriculture asked State and local administrators whether outreach was an administrative problem, which outreach techniques they used to inform potential eligibles about the program, and which outreach techniques had proven effective or ineffective. Fifty-two percent of the State administrators and 48 percent of the local administrators indicated that outreach was an administrative problem. The study reported:

> Administrators expressed their concern that the mandated increase in outreach imposed an unreasonable administrative burden on the State and local food stamp operations. Alluded to were the large expenditures required; the pressure to extend outreach to include recipient service activities; the lack of available staff; the frequent and detailed reporting requirements; the difficulty local offices would have in handling any increases in applications; and the impossibility of ever insuring participation by all eligibles persons. Administrators questioned the need for extensive outreach, arguing that public awareness of the program is high; they also questioned the efficacy of outreach in increasing participation by the needy. Another group of responses pointed to negative attitudes toward outreach on the part of county agencies, State legislatures, and the general public. Some administrators voiced their support of the outreach concept but complained of a lack of staff, time, and money to do an adequate job.[79]

The question on outreach techniques and their effectiveness listed: (1) information distributed to grocers, (2) information distributed to community groups, (3) door-to-door campaigns, (4) press releases, (5) television and radio spots, and (6) telephone campaigns (hot-line). Responses indicated that the techniques most widely used by State and local groups were television and radio spots, press releases, and information distributed to community groups. There had been little experience at the State or local levels with information distributed to grocers, door-to-door campaigns, or telephone campaigns. Among States with experience in these particular techniques, the one considered most effective was distribution to community groups, followed by distribution to grocers (95 percent effective), television and radio spots (87 percent effective), and press releases (83 percent effective). Local administrators considered television and radio spots most effective, followed by press releases, information to community groups, and information distributed to grocers.[80]

The most frequently cited problem raised by community groups (71 percent of those questioned) was outreach. They said:

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[78] Foreman Testimony, *Washington, D.C. Hearing*, p. 195.

[79] *Food Stamp Program*, p. 68.

[80] Ibid., pp. 81–84.

> . . .in their areas there was either no outreach effort or very little undertaken by the local food stamp office. Most of these respondents said more needed to be done, and several suggested the food stamp offices either contract with local community groups to aid in the outreach effort or make use of volunteers from the groups. Many also asked that existing laws be enforced and that the local food stamp office be required to undertake outreach.[81]

Some community groups noted, however, that "in their area expanded outreach was commencing, or that outreach was being successfully carried out by food stamp offices or community groups."[82]

In rating outreach techniques, the community groups indicated that they were most familiar with information distributed to community groups, press releases, and TV and radio spots. Of those who had experience with all of the techniques, they considered the following to be most effective: information distributed to community groups (81 percent); TV and radio spots (71 percent); door-to-door campaigns (71 percent); and telephone hot lines (64 percent).[83]

Transportation was treated separately in the House study, but it is considered to be part of outreach as defined by the Department of Agriculture. Of the community groups asked to identify problems in applying for food stamps, 82 percent cited transportation, making it the problem area most frequently identified.[84] A county opportunity council coordinator noted that 60 percent of the population lives outside the city where the welfare office is located. No public transportation from the rural to the city area exists and there is a large elderly population without private transportation.[85] Although they did not specifically address transportation, State and local administrators indicated that the elderly were a difficult group to serve, in part because of the difficulty they had in getting to the food stamp and issuance offices.[86]

The Commission was unable to identify any studies that have assessed the effectiveness of different outreach techniques for different age groups. Thus, it was not possible to evaluate the outreach programs of the States whose food stamp programs were reviewed to determine whether the outreach techniques they used were more effective for some age groups than for others. Recommendations for overcoming barriers to participation that were made by State and local administrators and community groups responding to the House Agriculture Committee's study of food stamps suggest that outreach for older persons should include home visits by certification workers, use of authorized representatives to purchase stamps, locating the food stamp office somewhere other than the welfare department, telephone interviews, development of community transportation, and better coordination between food stamps and Social Security/SSI benefits.[87] In evaluating the outreach activities of the States included in the age discrimination study, the Commission assessed the general attitude of administrators toward providing outreach and looked at whether their food stamp outreach programs had components that could alleviate some of the barriers to participation that had been identified in serving hard-to-reach groups such as the elderly.

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[81] Ibid., pp. 338, 340.
[82] Ibid., p. 365.
[83] Ibid., pp. 354–58.
[84] Ibid., p. 350.
[85] Ibid., p. 361.
[86] Ibid., p. 80.

The attitude of some administrators who were interviewed and, according to them, of some State legislators was not favorable toward an outreach program. In several instances it was clear that the reason outreach was being provided was still a direct result of the Court order that States do so. Byron Smith, chief of the Food Stamp Program Management Branch of the California Department of Benefit Payments, testified before the Commission:

> . . .outreach is, to put it delicately, a kind of controversial subject. It's a difficult concept for a lot of people to accept. You hear terms of going out and recruiting welfare recipients and that sort of thing. Of course, outreach has been on the books for some time. It wasn't until a 1975 lawsuit (*Bennett v. Butz*) that really put some teeth into it and everybody all of a sudden got serious about outreach. At that time we tried to treat it just like we do most of our mandates from the Federal Government, and that is to pass it on to the county welfare departments who are responsible, of course, in California for running the program on a day-to-day basis. And the counties, we have had a small revolt on our hands. . . .Most counties either ignored our mandate or did things like pass board of supervisors' resolutions against it and that sort of thing, which caused us obviously to go back and. . .rethink the thing, and we now operate the outreach program through community organizations in California where we at the State level contract with these people. They are responsible for providing outreach services in a particular geographic region, and the county role is basically limited to dealing with the referrals that come in from these organizations and a little bit of reporting we are trying to keep set up, so we can keep some track of things going on.[88]

The State information officer for social services in Missouri, who was responsible for developing public information materials for the food stamp program, told Commission staff that there was concern in his State that a "real outreach effort" would "open the flood gates." The State legislature was concerned that many applicants which such an outreach program would bring would not be eligible to receive food stamps. As a result, the State developed an outreach program emphasizing nutrition education rather than the mechanics of becoming eligible for the program.[89] According to the director of income maintenance of the State Department of Social Services, the Legal Aid Society in one city had filed a lawsuit contending that Missouri does not meet Federal outreach requirements. The suit was still being argued when Commission staff were conducting interviews.[90]

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[87] Ibid., pp. 80, 346–47.

[88] Byron Smith, chief, Food Stamp Program Management Branch, California Department of Benefit Payments, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27–28, 1977, vol. I., p. 125 (hereafter cited as *San Francisco Hearing*).

[89] Terry Puster, information officer, Missouri

Ronald Mikesell, director of food assistance for the Colorado Department of Social Services, testified that there was also a negative attitude about outreach in some areas of Colorado. Asked whether he thought the outreach program in the State was really working and getting positive results, he said:

> I would like to qualify that to a certain degree. We do have a little bit of negative opinion about outreach in some of our rural conservative counties. . . .[as] a matter of pride some of the local county authorities think that we are trying to identify them as being low income and they resent that. They feel that the food stamp program has been very well publicized, that everyone knows about it, but yet we know for a fact that the things they do know are not the things that are going to help them to participate but conversely would be things that would prevent them from participating. I think we need to overcome that with positive outreach.[91]

Leo Davenport, supervisory food program specialist responsible for the Outreach and Civil Rights Unit of the Food and Nutritition Service in the Department of Agriculture's Atlanta office, concurred that reluctance to conduct outreach exists among program administrators. Asked whether he had encountered difficulties in conducting outreach because of the view that people should not be trying to increase Federal expenditures in the food stamp program, he said:

> . . .some of those attitudes still prevail. I think that they probably are not as great as they were back in the Project FIND days but we still find people who have. . .[the attitude] that you really shouldn't drag people into the office. . . .[S]ome people even question the need for outreach.[92]

Resistance to providing outreach was also indicated in the Illinois outreach plan for January 1, 1977, through June 30, 1977. The plan states that the agency is "experiencing very minor reluctance on the part of contacted groups, agencies, organizations, or individuals to assist in providing some type of food stamp outreach to service their people."[93] The plan noted that:

Division of Social Services, interview in St. Louis, Mo., Apr. 7, 1977 (hereafter cited as Puster Interview).

[90] Tom McLaughlin, director, Income Maintenance, Missouri Department of Social Services, interview in Jefferson City, Mo., May 8, 1977 (hereafter cited as McLaughlin Interview).

[91] Ronald S. Mikesell, director of food assistance, Colorado Department of Social Services, testimony, *Hearing Before the U.S. Commission on Civil Rights, Denver, Colorado*, July 28–29, 1977, vol. I., pp. 125–26 (hereafter cited as *Denver Hearing*).

[92] Leo Davenport, supervisory food program specialist, Outreach and Civil Rights Unit, Food and Nutrition Service, U.S. Department of Agriculture, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida*, Aug. 22–23, 1977, vol. I., p. 121 (hereafter cited as *Miami Hearing*).

[93] State of Illinois, Department of Public Aid, *Food Stamp Program — Illinois Semi-Annual Outreach Report : July 1, 1976, through December 30, 1976*, p. 20 (hereafter cited as *Illinois Plan*).

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> . . .agencies or organizations which have exhibited reluctance or outright refusal to assist in Outreach activities have done so on the basis of their desire to receive financial assistance from the Agency.[94]

This raises the question whether and to what extent States fund outreach efforts, since outreach is considered an administrative cost for which the State must provide 50 percent of the costs. The importance of the availability of funding for outreach was indicated by Byron Smith, chief of food stamp management of the California Department of Benefit Payments. Mr. Smith, when asked to identify the disincentives to outreach efforts, replied that only 50 percent of the funds for "administrative costs to deal with the people that are coming in the front door" are Federal funds.[95] Others told the Commission that their outreach activities had been made possible because of grants they had received from the U.S. Community Services Administration. Ronald Mikesell of the Colorado Department of Social Services testified:

> . . .we have some funds through State agency appropriations but this has been extremely limited. . . .[W]e have been fortunate to get a grant of $124,000 from the Community Service Agency. . . .[96]

Thomas Smithdale, food stamp coordinator for the Florida Department of Health and Rehabilitative Services, testified:

> The outreach program is funded jointly 50–50 matched between State revenue funds and USDA [U.S. Department of Agriculture] Federal matching funds.
>
> However, [in] the State of Florida food stamp program. . .we have been very fortunate to receive two Federal grants totaling almost a million dollars in CSA [Community Services Administration] funds which were matched by USDA dollars. . . .We've used this money to employ 77 individuals to work in the food stamp program around the State, 11 of whom. . .are district regional coordinators.
>
> We've also hired additional certification workers, and in a kind of a novel approach we've hired 23 people called social worker assistants who actually go out and pick up the money from people and return the stamps to them and perform other outside office functions. . .[and] act as representatives for persons who can not act in their own capacity.[97]

The House Agriculture Committee's report on the Food Stamp Act of 1977 states that "[t]he Department [of Agriculture] in 1975 approved the use of CSA funding for the State share of outreach costs" and that some States "have plans to use Community Services Administration

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[94] Ibid.

[95] Smith Testimony, *San Francisco Hearing*, p. 128.

[96] Mikesell Testimony, *Denver Hearing*, p. 124.

[97] Thomas Smithdale, food stamp coordinator, Florida Department of Health and Rehabilitative Services, testimony, *Miami Hearing*, p. 118.

(CSA), formerly OEO, moneys to pay their share (50 percent) of outreach costs." This funding, it reports, is "channeled to the local level through CSA's Community Food and Nutrition Program. . . ."; however, "less than three hundred community action agencies have 'food and nutrition' grants from the CSA that involved food stamp work."[98]

The extent to which States' expenditures for outreach can vary is suggested by budget information included in the outreach plans of three States for the first 6 months of 1977. Missouri indicated that it planned to spend $32,000; Mississippi indicated that it would spend $114,000; and California stated that its expenditures would be $580,000.[99]

Despite reluctance in some areas and by some administrators to conduct outreach, the Commission did find that some outreach was being conducted in all of the States reviewed as part of the age discrimination study. What set some efforts apart were the outreach techniques used and the target groups identified for special outreach efforts. The Commission determined from the field study, public hearings, and review of States' outreach plans for January 1 to June 30, 1977, that the techniques used most often include the following: providing information to other groups (eight States), providing information and literature generally (six States), and use of television and radio announcements (seven States). Other outreach activities included transportation (five States), home certification (four States), door-to-door canvassing (three States), telephone interviews (three States), use of authorized representatives to purchase stamps (two States), and establishing itinerant sites for certification and purchase of stamps (one State). These activities are discussed below.[100]

Contact with Other Groups

The groups to whom information was provided differed markedly from State to State, but tended to follow the listing of groups in the Department of Agriculture's outreach instruction materials.[101] These are mainly organizations serving a wide range of age groups, including older persons and children.[102]

Published Literature/Posters

Literature that the State agencies distributed consisted primarily of materials developed by the Department of Agriculture.[103] Some of these materials were available in language appropriate to the ethnic groups in the State.[104]

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[98] *Food Stamp Report*, pp. 341–42.

[99] State of Missouri, *Food Stamp Outreach Plan : January 1, 1977; to June 30, 1977* ; State of Mississippi, *Food Stamp Outreach Plan : January 1, 1977 to June 30, 1977* ; State of California, *Food Stamp Outreach Plan : January 1, 1977 to June 30, 1977* (hereafter cited as *California Plan*).

[100] Determination of techniques used most often was based on whether a particular outreach technique was mentioned as being used, either in an interview conducted by Commission staff or in the States' outreach plans. Information was not available to enable Commission staff to determine how frequently techniques were employed or States' comparative expenditures for different types of outreach offered within the State.

[101] *State Outreach Instructions*, exhibit A.

[102] *Illinois Plan*, pp. 19–20; State of Maine, Department of Human Services, *Food Stamp Outreach Action Plan : January 1, 1977 through June 30, 1977*, p. 7 (hereafter cited as *Maine Plan*); Michael Padelford, financial service supervisor II, Kent County Economic and Social Services Office, Community Services Division, Washington State Department of Social and Health Services, interview in Kent, Wash., Apr. 28, 1977 (hereafter cited as Padelford Interview).

Media

Seven States—Maine, Florida, Illinois, California, Washington, Colorado, and Mississippi—emphasized providing information through the media.[105] One State's outreach plan indicated that the food stamp agency:

> . . .has and will continue the practice through its Office of Public Affairs and Communications at the State level and through its local offices to promptly inform TV and radio stations and each newspaper. . .of changes in the Food Stamp program.[106]

Illinois, while providing information through the media, noted in its outreach plan:

> Since the Food Stamp Program, as well as the categorical assistance program, are State administered programs (central), this concept precludes local office administrators to arbitrarily release information to the press, appear on radio/television programs, or permit their respective staff to do the same. To permit this would be uncontrollable and would eventually lead to disaster because of the complexities inherent within the Food Stamp Program.[107]

This statement suggests that the use of media to advertise the program may be only a partial response to limited participation, since it may not be appropriate for addressing local rather than statewide problems.

Transportation

Transportation was provided by the staff of only one of the nine State agencies visited during the Commission's study—Illinois. There, the transportation was limited to older persons and was provided on request.[108] In five other States—Washington, Mississippi, Colorado, Florida and Maine—program administrators indicated or State plans stated that transportation would be provided by volunteers.[109] Mississippi's plan also stated that transportation was available to older persons from the State agency on aging and from community action agencies.[110]

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[103] *Maine Plan,* p. 3; Puster Interview; *Illinois Plan,* pp. 14-15; Holly Sherman, food stamp program specialist, Office of Income Maintenance, Community Services Division, Washington State Department of Socialand Health Services, interview in Seattle, Wash., Apr. 28, 1977 (hereafter cited as Sherman Interview).

[104] *Maine Plan,* pp. 4-5; *Illinois Plan,* pp. 14-15, Sherman Interview.

[105] *Maine Plan,* p. 2; State of Florida, *Food Stamp Outreach Plan: January 1, 1977 through June 30, 1977* (hereafter cited as *Florida Plan*); *Illinois Plan,* pp. 2-3; *California Plan;* Padelford Interview; State of Colorado, *Outreach Plan: January 1, 1977 through June 30, 1977* (hereafter cited as *Colorado Plan*); Ester Denson, State coordinator, Food Stamp Assistance, interview in Jackson, Miss., Apr. 26, 1977 (hereafter cited as Denson Interview).

[106] *Maine Plan,* p. 2.

[107] *Illinois Plan,* p. 2.

[108] Ibid., pp. 10 and 21.

[109] *Maine Plan,* p. 5; *Florida Plan,* p. 1; State of Washington, *Washington State Food Stamp*

Where transportation was not available statewide, State and local administrators indicated that its absence created a unique problem for older persons. The information officer in the Missouri State Division of Social Services said that the food stamp outreach program in the State did not encompass transportation, and consequently the homebound and isolated elderly who cannot get to the food stamp office are not able to participate in the program.[111] In Washington, the food stamp program specialist in the Department of Social and Health Services stated that lack of transportation has presented a particular problem in rural areas, and the problem is worse for older persons who no longer drive. In this instance, the State has tried to minimize problems caused by lack of transportation by providing home visits, using a mobile sign-up unit, mailing applications, stationing workers in outlying communities at certain times, and using volunteers.[112]

Home Certification of Applicants

Four States—Maine, Illinois, Washington, and Texas— employ home certification of applicants for food stamps. They use home certification where transportation is not readily available or to reach homebound persons who could not make use of transportation.[113] Ronald Mikesell, food assistance director for the Colorado Department of Social Services, said that home certification has been particularly beneficial to the elderly:

> We have been fortunate in Colorado to have some funding from the Community Services Agency which has allowed us to hire some part-time staff who can go out and reach the elderly and the disabled to find those who need the benefits of the program, and while they are there accomplish the certification so that are able to be certified without having to come into the certification office. As a result of that we feel that this outreach has been especially beneficial to the elderly. We have brought people into the program that we know would not have been there other than that and have helped them have a more adequate diet because of it.[114]

Door-to-Door Canvassing

Two States—Texas and Illinois—conducted door-to-door canvassing to identify persons eligible for the food stamp program. The food stamp agency in Illinois had signed a contract with the State

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Outreach Plan: January 1, 1977 through June 30, 1977 (hereafter cited as *Washington Plan*); *Colorado Plan;* and Denson Interview.

[110] Denson Interview.

[111] Puster Interview.

[112] Sherman Interview.

[113] *Maine Plan,* p. 2; Tim Grace, Illinois State director for the food stamp program, interview in Springfield, Ill., May 25, 1977 (hereafter cited as Grace Interview); Sherman Interview; Pete Tristan, regional director for financial services, Texas Food Stamp Program, interview in San Antonio, Tex., Apr. 26, 1977 (hereafter cited as Tristan Interview).

[114] Mikesell Testimony, *Denver Hearing,* p. 124.

office on aging to conduct a special, door-to-door, outreach effort to locate eligible older persons. Food stamp officials in the State pointed out that this program is the result of strong advocacy on the part of groups representing the interests of older persons.[115] In Texas, three outreach caseworkers had been hired exclusively to conduct door-to-door canvassing and complete applications for persons interested in applying to the program. This door-to-door outreach was targeted in census tracts with high concentrations of older persons.[116]

Telephone Contact

Four States—Maine, Illinois, Washington, and Mississippi—used some form of telephone information and referral to inform persons about food stamps and identify eligible individuals. In Maine, toll free and publicized telephone numbers were established in each regional office of the State to provide information about the food stamp program.[117] In Illinois, volunteers made phone calls to identify eligible individuals.[118] In Washington, telephone information and referral was identified as one of the major components of the food stamp program.[119] Mississippi depended on the telephone information and referral system of the State agency on aging to provide information to older persons; however, the State coordinator for food stamp assistance noted that such a system is ineffective for reaching people who do not have a telephone, which she said was the case for many people in the rural areas of the State.[120]

In Colorado, consideration was being given to developing a food stamp "hotline," but it had not yet been initiated.[121] California used a statewide information and referral system to provide older persons with phone numbers and addresses of food stamp offices.[122]

Other Efforts

Colorado and Maine used volunteers to act as authorized representatives for persons who could not get out to purchase stamps themselves.[123] One State, concerned about identifying SSI recipients who were eligible but not receiving food stamps, compared its list of food stamp eligibles to the Social Security office's list of recipients of supplemental security income. Letters were sent to persons who were found not to be participating in the food stamp program.[124] This contact with the Social Security Administration to ensure participation in the food stamp program by persons receiving supplemental security income is particularly important because these individuals are removed from contact with State welfare departments, which are responsible for the administration of the food stamp program. As Robert Greenstein, Special Assistant to the Secretary of Agriculture, testified before a hearing of the Senate Special Committee on Aging in April 1977:

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[115] Grace Interview.

[116] Ron Gossen, Texas Department of Public Welfare, interview in San Antonio, Tex., Apr. 26, 1977; Tristan Interview.

[117] *Maine Plan*, p. 2.

[118] *Illinois Plan*, p. 4.

[119] *Washington Plan*.

[120] Denson Interview.

[121] *Colorado Plan*.

[122] California Plan.

[123] *Colorado Plan; Maine Plan*, p. 2.

[124] Smithdale Testimony, *Miami Hearing*, p. 119.

> We were very concerned when the SSI program moved out of the State welfare office, where you used to apply for help for the aged and where you still apply for the food stamps. When SSI went to the Social Security office, this link was broken. We are concerned with the various ways of repairing that break.[125]

These activities indicate that, at least in their outreach plans, some State agencies administering the food stamp program are planning a wide range of outreach activities, some of which are directed at hard-to-reach populations, including older persons. Ensuring that these plans are implemented will require, however, commitment at the State and local levels and careful evaluation and monitoring by the Department of Agriculture.

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[125] *Food Stamp Effectiveness*, p. 18.

Chapter 7

Vocational Rehabilitation Services

The vocational rehabilitation services program is authorized by the Rehabilitation Act of 1973, as amended,[1] which authorizes the provision of grants to States to meet part of the cost of rehabilitating handicapped individuals to prepare for and engage in gainful employment to the extent of their capabilities.[2] Emphasis is placed on providing services to those with severe handicaps.[3]

A review of the program found discriminatory practices on the basis of age in several areas. Although the proportion of the disabled and severely disabled populations increases with age, the proportion of vocational rehabilitation clients declines by age. Program data indicate that persons aged 45 or over are underserved. Although the program's goal is to rehabilitate handicapped individuals for "gainful employment," program administrators stress competitive employment. This helps restrict participation by those 45 or over when taken together with the relative lack of outreach found in the program and age discrimination in employment. Federal program performance standards stress competitive employment placements, which are reported to discourage indirectly counselors from accepting cases involving older persons. Some States have policies that require consideration of age in determining eligibility for services. Special outreach activities and referral sources are not used for older persons. The program's reliance on the job market for placement in competitive employment leads to a focus on those individuals it is believed the labor market will accept—namely, younger persons. Since employment is a goal of the program, good relationships with employers are needed by program counselors and administrators.

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[1] Rehabilitation Act of 1973, Pub. L. No. 93–112, 87 Stat. 355, as amended by Pub. L. No. 93–516, 88 Stat. 1617 [codified at 29 U.S.C. §§701–794 (Supp. V 1975)].

[2] 29 U.S.C. §720(a) (Supp. V 1975).

[3] 29 U.S.C. §§701(1); 721(a)(5)(A) (Supp. V 1975).

This makes it difficult for them to raise questions or act when they confront instances of age discrimination in employment. The belief in a better return for the investment of funds is a rationale sometimes used to explain or justify aiming the program at younger clients. Finally, some staff exhibit negative attitudes toward older persons, and this appears to affect whether they will provide services to or seek out older persons.

Program Description

The Smith-Fess Act of 1920 established the vocational rehabilitation program to provide Federal funds to meet part of the costs of operating a State program for training, counseling, and job placement services on behalf of those disabled in industry or a legitimate occupation.[4] Since that time the Congress has acted several times to revise and expand the program, most recently with the Rehabilitation Act of 1973 which "comprised a total legislative revamping" of the program.[5] The purpose of the current vocational rehabilitation (VR) program is:

> . . .to assist States to meet the current and future needs of handicapped individuals, so that such individuals may prepare for and engage in gainful employment to the extent of their capabilities.[6]

Each year a State is eligible to receive up to 80 percent of the cost of operating the program under an approved State plan. The balance of any costs are to be met with non-Federal funds. Federal allocations to each State are based on a statutory formula that is applied against the annual appropriation for the program.[7]

To participate in the program, a State must submit an annual plan for vocational rehabilitation services to the Secretary of Health, Education, and Welfare for approval. The plan must designate a single State agency to administer or supervise the administration of the plan, except that a State may designate a separate agency for the blind. If a separate agency for the blind is designated, it is responsible only for the part of the plan that concerns services to the blind.[8] The State VR plan must specify the plans, policies, and methods the State will follow in conducting the program.[9]

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[4] National Civilian Vocational Rehabilitation (Smith-Fess) Act, ch. 219, 41 Stat. 735 (1920).

[5] U.S. Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on the Handicapped, *Rehabilitation and Developmental Disabilities Legislation*, 94th Cong., 2nd sess., 1976, Comm. Print., p. vii.

[6] 29 U.S.C. §720(a)(Supp. V. 1975).

[7] 29 U.S.C. §§706(5); 720(b); and 730(a) (Supp. V 1975).

[8] 29 U.S.C. §721(a) (Supp. V 1975). In fiscal year 1976, 25 States had separate agencies for the blind. U.S., Department of Health, Education, and Welfare, Office of the Secretary, *Annual Report to the President and the Congress on Federal Activities Related to the Administration of the Rehabilitation Act of 1973 as amended, Fiscal Year 1976*, p. 12.

[9] 29 U.S.C. §721 (Supp. V 1975).

Persons eligible for services under a State VR program must be handicapped, which is defined as follows:

> . . .any individual who. . .has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and. . .can reasonably be expected to benefit in terms of employability. . .[10]

Federal regulations define "employability" as involving a determination that an individual, after receiving services, is likely to be able to:

> . . .to enter or retain employment consistent with his capacities and abilities in the competitive labor market; the practice of a profession; self-employment; homemaking; farm or family work;. . .sheltered employment; homebound employment; or other gainful work.[11]

In response to allegations that those with the most severe handicaps were not being served adequately,[12] the Rehabilitation Act of 1973 underlined the need for services for the severely handicapped and the responsibility of the VR program to meet that need. "Severe handicap" means a disability requiring multiple services over an extended period of time and resulting from any of several specified causes.[13] A State VR plan must describe the methods the State will use to expand and improve services to the severely handicapped and assure that when services cannot be provided to all handicapped individuals who apply, the severely disabled will be served first.[14] Any goods and services necessary to render a handicapped individual employable may be provided under the program including the following:

- evaluation of rehabilitation potential to determine eligiblity for program;
- counseling, guidance, referral, and placement services, including followup;
- vocational and other training services;
- physical and mental restoration services, including surgery and prosthetic devices;
- maintenance during rehabilitation;
- interpreter and reader services;
- recruitment and training services;
- rehabilitation teaching services and orientation and mobility services for the blind;

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[10] 29 U.S.C.§ 706(6)(Supp. V. 1975).

[11] 45 C.F.R. §1361.1(g) (1976).

[12] U.S., Congress, Senate, Committee on Labor and Public Welfare, *Rehabilitation Act of 1972*, 93d Cong. 1st sess., 1973, S. Rept. 318, p. 4 (hereafter cited as *Report on Rehabilitation Act of 1972*).

[13] 29 U.S.C. §706(12) (Supp. V 1975). The specified causes of severe handicaps may be amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia and other spinal cord conditions, renal failure, respiratory or pulmonary dysfunction, and any other disability specified in Federal regulations.

[14] 29 U.S.C. §721(a)(5) (Supp. V 1975).

- occupational licenses, tools, equipment, and initial stocks and supplies;

- transportation; and

- telecommunications, sensory, and other technological aids and devices.[15]

At a minimum a State plan must provide for the first three services. The remainder must be provided as needed after "full consideration of [the individual's] eligibility for similar benefits under any other program," except physical and mental restoration services and maintenance, where such consideration is not necessary if it would delay provision of those services.[16] Services provided for groups of handicapped individuals may also include management services and supervision for any small business operated by a group of the severely handicapped, the construction or establishment of public or nonprofit rehabilitiation facilities, and the provision of other facilities or services.[17] In addition to the services specified in the statute, the following must be available, as appropriate, under a State VR plan:

- services to members of a handicapped individual's family when necessary to the adjustment or rehabilitation of the handicapped individual;

- placement in suitable employment;

- post-employment services necessary to assist the handicapped individual maintain suitable employment; and

- other goods and services which can be expected to benefit a handicapped person in terms of employability.[18]

The rehabilitation process can best be described as "a sequence of services designed to move the handicapped client toward the goal of placement in a gainful occupation."[19] The VR counselor provides counseling and coordinates and monitors the individual's movement through a series of recorded progressions call "statuses" that identify the particular point that the individual has reached in the rehabilitation process. The key statuses are referral, applicant, extended evaluation, active caseload, successfully rehabilitated, and case closed but not rehabilitated. A case is opened when the VR agency has contact with, or receives some specific information about, an individual. A case is closed when the individual is removed from the VR caseload either before or after any services are delivered. The major statuses used by the VR program to classify client treatment are defined below:

Referral— The referral status represents entrance into the VR process. A "referral" is any individual who has applied or been referred to the vocational rehabilitation agency by letter, telephone, direct contact, or any other means, and about whom certain minimum information has been obtained.[20] An individual comes into contact with a VR agency either on his or her own initiative or by referral from some source such as a hospital, educational institution, or public agency. The major public agency referral source is the Social Security Administration (SSA).[21]

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[15] 29 U.S.C. §723 (Supp. V 1975).
[16] 29 U.S.C. §721(a)(8) (Supp. V 1975).
[17] 29 U.S.C. §723 (Supp. V 1975).
[18] 45 C.F.R. §1361.40 (1976).
[19] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, *Report of the Comprehensive Needs Study*, prepared by the Urban Institute (1975)(hereafter cited as *Comprehensive Needs Study*).

Local SSA disability determination units refer disability insurance (DI) applicants or supplemental security income (SSI) applicants who are disabled or blind to the VR agency to determine if they are eligible to receive services.[22] SSA funds may pay for VR services if it is anticipated that (1) these services are likely to result in productive employment; (2) the cost of the services will be offset by a reduction in or elimination of future DI or SSI benefits; and (3) in the case of DI, the cost will also be offset by expected contributions to the social security trust fund.[23]

Applicant— When a referred individual has signed a document requesting VR services, he or she is placed into the "applicant" status.[24] A VR counselor then determines if the individual meets the definition of a handicapped individual and is thereby eligible to receive services. This determination includes a diagnosis of the individual's handicap, evaluation of rehabilitation potential, and determination of the scope of services to be provided.[25]

For the VR agency to receive reimbursement from SSA for services provided to DI or SSI recipients, the VR counselor must also determine whether the individual is eligible to have the Social Security Administration pay for the services.[26]

Extended Evaluation— If it cannot be determined whether an individual meets the definition of a handicapped individual or whether a vocational goal is feasible, an applicant may be accepted for an extended evaluation of up to 18 months to determine his or her rehabilitation potential.[27] If it is determined at any point during extended evaluation that the individual meets the definition of a handicapped individual and a vocational goal is defined, he or she is then moved into the active caseload status.

Active Caseload— Once an individual is determined eligible for services, an individual written rehabilitation program (IWRP) is developed jointly by the individual (or parents or guardians, if appropriate) and the VR counselor. The IWRP identifies the individual's long-range employment goal and the steps that will be taken to achieve the objectives and overall goal.[28] After the IWRP is complete, the client moves through various active caseload statuses, depending on the kind of services received.[29]

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[20] 45 C.F.R. §1370.2(e)(1) (1976).

[21] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, HEW Information Memorandum, RSA-IM-77-37, "Distribution of Source of Referral of Cases Closed by State Vocational Rehabilitation Agencies During Fiscal Year 1975," Feb. 11, 1977.

[22] 42 U.S.C. §422(a) (1970); 42 U.S.C. §1382d(a) (Supp. V 1975).

[23] 42 U.S.C. §422(a) (1970); 45 C.F.R. §1361.124 (1976).

[24] 45 C.F.R. §1370.2((e)(2) (1976).

[25] 29 U.S.C. §723(a)(1) (Supp. V 1975).

[26] 45 C.F.R. §§1361.114, 1361.124 (1976).

[27] 29 U.S.C. §706(4)(G) (Supp. V 1975).

[28] 29 U.S.C. §§721(a)(9), and 722(a) (Supp. V 1975). An individual written rehabilitation program (IWRP) must be developed for an individual placed in any active caseload or extended evaluation status. 45 C.F.R. §1361.39(a) (1976). The time when

Successfully Rehabilitated— A client is considered sucessfully rehabilitatd when, among other things, a suitable employment objective has been maintained for at least 60 days.[30]

Not Rehabilitated— A client is considered "not rehabilitated" if his or her case is closed before rehabilitation is completed. A case may be closed before rehabilitation services are initiated, if the client does not complete the program of services, or if the client does not obtain suitable employment for at least 60 days.[31]

The vocational rehabilitation program is administered at the Federal level by the Rehabilitation Services Administration, which is located within the Office of Human Development Services of the Department of Health, Education, and Welfare. There is a corresponding unit in each of the 10 regional offices of the Department.[32]

Summary of the Record

Program Participants

Analysis of data for the vocational rehabilitation program reveals marked differences between the age distribution of the client population and that of the disabled and severely disabled populations. Older disabled adults (45+) are not represented in the service population in the same proportion as they are found in the disabled or severely disabled populations. Further, the older disabled are not represented in the client population in the same proportion as they are in the disabled population reported to be in the labor force. Older disabled individuals who manage to gain entry to the VR program exhibit successful rehabilitation rates that are as good as those for younger age groups. The major problem with regard to participation of persons 45 or over in the VR program appears to center on the ability of such persons to get into the program.[33]

VR data are reported for all persons who were in at least the referral status and whose cases were closed from the VR caseload for any reason during that year. Thus, data are available for persons whose

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the IWRP is being developed is classified as a status within the rehabilitation process.

[29] 45 C.F.R. §1370.2(e)(6) (1976).

[30] 45 C.F.R. §1361.41(a)(4) (1976).

[31] 45 C.F.R. §1370.2(e)(8)–(9) (1976).

[32] 29 U.S.C. §702(a) (Supp. V 1975).

[33] See Michael Gutowski and Jeffrey Koshel, *Methods for Assessing Age Discrimination in Federal Programs* (Washington, D.C.: The Urban Institute, 1977) pp. 11–39 (hereafter cited as *Assessing Age Discrimination*). As part of the Age Discrimination Study, the U.S. Commission on Civil Rights contracted with the Urban Institute to review and analyze data for selected Federal programs. The institute's analysis of a 10 percent sample of fiscal year 1974 data for the vocational rehabilitation (VR) program was the basis for this section on program participants. Their data have been modified to reflect the entire VR caseload where such data were available from the Rehabilitation Services Administration and to incorporate data from a 25 percent sample for fiscal year 1976 made available to Commission staff after the Urban Institute's work. Also, additional analysis and data are presented based on comments received from the staff of the Rehabilitation Services Administration and other reviewers.

cases are closed at the referral and applicant statuses, and for persons whose cases are closed after they have been accepted for services, regardless of whether they received any services. The information collected for each status includes the age of the individual at the point of referral, which is the same age reported when the case is closed from the VR caseload, regardless of any intervening time.[34] The data permit analysis by age of all who have come into contact with the program, those who have been accepted or rejected for VR services, those who have been rehabilitated, and those who have not been rehabilitated.

Data presented in this chapter for fiscal years 1974 and 1976 are reported from the complete program data file which was furnished by the Rehabilitation Services Administration (RSA). Several special cross-tabulations were done to analyze differences by age, using computer tapes of a sample of the data file, referred to as the R–300 file. For fiscal year 1974, a 10 percent sample of the records for each type of client status at the time of case closure was used, resulting in 91,885 records. For fiscal year 1976, a 25 percent sample consisting of 263,267 records was used. Unless otherwise indicated, however, data used are from the entire R–300 file.

As reported by the Rehabilitation Services Administration,"[t]here was no significant change in the distribution of rehabilitated clients by age at the time of referral" between fiscal years 1972 and 1976.[35] Rehabilitated clients include only those persons who have been determined eligible for VR services and whose cases have been closed as successfully rehabilitated. For each of the 5 years, at least 23 percent of all rehabilitated persons were 19 years of age or younger, and at least 60 percent were under 35 years. At the same time, less than one-fourth were 45 or older, and 2 percent or less were 65 or older. Both the mean and the median ages at referral for rehabilitated clients have remained about the same over the entire period, with the mean age approximately 32 years. (See table 7.1.)

Data presented in the remainder of this chapter are for different fiscal years, depending on available tabulations for different information categories. However, since few differences in the age distributions of individuals are reported on a year-to-year basis, use of data for various fiscal years should not affect comparisons. Whenever possible, data for more than 1 year are shown to demonstrate the consistency with which different age groups have been represented in the program from year to year.

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[34] The Federal data file derived from the R–300 forms includes data on all VR clients whose cases are closed. The file provides no information on the characteristics of clients currently receiving services. The only information available for those closed at referral or applicant status consistent with other closure statuses are disability type, age, sex, date of referral, and source of referral.

[35] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, HEW Information Memorandum, RSA–IM–77–21, "Preliminary Report on Characteristics of Clients Rehabilitated During Fiscal Year 1976," Dec. 22, 1976.

Table 7.1
Percent Distribution of Persons Rehabilitated By State Vocational Rehabilitation Agencies by Age, Fiscal Years 1972-1976

Age at Referral	Persons Rehabilitated				
	1972[a]	1973[a]	1974[a]	1975[a]	1976[b]
All Ages	100.0%	100.0%	100.0%	100.0%	100.0%
Under 18	13.4	14.1	14.2	13.4	13.4
18-19	11.1	11.4	11.4	10.6	10.1
20-24	16.5	17.7	18.0	17.1	16.9
25-34	19.0	19.7	20.3	21.3	21.8
35-44	15.9	15.0	14.5	14.9	14.9
45-54	14.2	13.2	12.7	13.4	13.3
55-64	8.3	7.4	7.1	7.5	7.5
65 or over	1.6	1.5	1.8	1.8	2.0
Mean Age	32.6	31.8	31.8	32.2	32.3
Median Age	29.4	28.0	28.2	29.2	29.3

Source: [a] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, HEW Information Memorandum, RSA-IM-77-21, "Preliminary Report on Characteristics of Clients Rehabilitated During Fiscal Year 1976," December 22, 1976.

[b] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, HEW Information Memorandum, RSA-IM-77-71, "Final Report on Characteristics of Clients Rehabilitated During Fiscal Year 1976," June 8, 1977.

Data for fiscal years 1974 and 1976 were analyzed for 5 year age intervals for those persons who had been accepted for any VR services. This includes those whose cases were closed from extended evaluation status and those whose cases were closed as successfully rehabilitated or not rehabilitated (either where services had been given or not given). (Services delivered during the period of extended evaluation are supposed to be only diagnostic and evaluation services to determine the rehabilitation potential of the individual. These services may be provided for up to 18 months.[36])

Comparisons of data reported for each year demonstrate little change in the age at referral of individuals accepted for VR services. In both years more than half of the VR clients were under 30 years of age, less than 10 percent were 55 or older, less than 5 percent were 60 or over, and less than 2 percent were 65 or older. (See table 7.2)

To determine if age might be a factor in who was accepted for VR services, client data for fiscal year 1976 were compared with the age distribution of the disabled population as reported by the Social Security Administration's 1972 survey of the disabled, the most widely used source of data on the incidence of disability. Furthermore, since the Rehabilitation Act of 1973 requires that priority be given to individuals with severe handicaps, the data were also compared with data on the severely disabled. However, because the survey of the disabled covers only persons

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[36] 29 U.S.C. §706(4) (Supp. V 1975).

Table 7.2
Percent Distribution of Persons Accepted for Vocational Rehabilitation Services Whose Cases Were Closed by Age, Fiscal Years 1974 and 1976

Age at Referral	Persons Whose VR Cases Were Closed in FY 1974			Persons Whose VR Cases Were Closed in FY 1976		
All Ages	100.0%			100.0%		
Under 20	25.2	55.3		24.2	54.6	
20-24	18.3			17.6		
25-29	11.8			12.8		
30-34	8.8			9.5		
35-39	7.5			7.7		
40-44	7.3			7.2		
45-49	7.0			7.0		
50-54	5.9			5.9		
55-59	4.3		8.3	4.2		8.1
60-64	2.4	4.0		2.4	3.9	
65 or over	1.6			1.5		

Source: U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from the R-300 File for Fiscal Years 1974 and 1976.

between the ages of 20 and 64, over 25 percent of the VR client data were eliminated from this comparison by the exclusion of those under 20 and over 64.

Social Security data are not strictly comparable to VR data. The Social Security Administration defines persons unable to work at all [illegible] severely disabled. Occupationally [illegible] are those unable to work at the job [illegible] prior to the onset of disability or those unable to work full-time. Those able to work full-time on a regular basis but with limitations on the kind or amount of work they can perform are classified as having secondary work limitations. In addition, the data collection procedures used by SSA and RSA vary. Nevertheless, the Social Security data represent the best approximation of the population eligible for VR services.

The data show that the proportion of both the disabled and the severely disabled populations increases with age, but the proportion of VR clients accepted for services declines with age. These data demonstrate that older persons are significantly underrepresented among those accepted for VR services. Persons under 45 make up a larger proportion of the VR cients than they represent in the disabled or severely disabled populations. Those 45 or over are consistently underrepresented, with the disparities increasing by successive age group. (See table 7.3.)

The Chief of the Statistical Analysis Branch of the Rehabilitation Services Administration suggested to Commission staff that VR client data should be compared to the disabled population in the labor force instead of to the general disabled population. He asserted that disabled labor force data would be a more accurate representation of the target population for VR services, since they do not include those who have retired or do not want to work and, therefore, would be less likely to want to participate in the VR program.[37] Use of disabled labor force data, however, presents several issues. First, the definition of labor force participation eliminates those individuals whose occupation is homemaker. According to Arabella Martinez, Assistant Secretary for Human Development Services of the Department of Health, Education, and Welfare, the homemaker occupation has been a long-time legitimate employment goal of the VR program; [38] therefore, the VR target population should include the disabled in that occupation. Labor force data also fail to include discouraged workers; that is, persons who are not working and are not actively looking for employment because they think they will not be able to find any. Discouraged workers do not meet the definition of unemployment and therefore are not recorded as being in the labor force. As for retired persons, the 1972 survey of the disabled was limited to persons aged 20 to 64, thus eliminating persons 65 or older who have retired. The data do, however, include those under 65 who may have retired before reaching 65.[39]

Comparison between the disabled in the labor force and persons accepted for VR services in fiscal year 1976 show an underrepresentation of individuals 45 or over in the VR caseloads. Nearly 25 percent of the disabled labor force was under 35, but they accounted for over half of the VR clients. On the other hand, 57 percent of the disabled labor force was 45 to 64, and yet only 26 percent of the VR clients were in that age category. Over a quarter of the disabled population in the labor force was 55 to 64, but the age group represented only 9 percent of persons accepted for VR services. (See table 7.4.)

A review of the age distribution of VR cases at the time of closure provides a

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[37] Lawrence Mars, Chief, Statistical Analysis Branch, Rehabilitation Services Administration, interview in Washington, D.C., Dec. 17, 1977.

[38] Arabella Martinez, testimony, *Hearing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Sept. 26–28, 1977, vol. I., p. 178 (hereafter cited as *Washington, D.C. Hearing*).

[39] A significant relationship exists between the Commission's use of the general disabled population from the 1972 SSA survey and the eligibility data base employed in the Comprehensive Needs Study (CNS). The study was mandated by the 1973 Rehabilitation Act Amendments and was carried out by the Urban Institute (UI) under contract with the Department of Health, Education, and Welfare (HEW). It was published by HEW as its report and submitted to the Congress.

The Office of Human Development Services of the Department has been using the results of the study in its budget justifications and legislative initiatives for fiscal year 1979. The UI used the 1966 Social Security *Survey of the Disabled* as the eligibility base for its analysis of needs and comparison with VR program participants. UI did not use a subset of the 1966 survey confined to labor force data but the entire disabled population. According to the director of the project, if the results of the 1972 survey had been available at the time, UI would have used them and used the full survey population, not the labor force subset. Jerry Turem, interview in Washington, D.C., Feb. 17, 1978. In work carried out under contract with the Commission, the 1972 survey was also used by the Urban Institute as the basis of its analysis.

UI also used estimates of the 1975 disabled population based on the 1966 survey, a technique used in the CNS. For methodological reasons, UI could provide only two age classifications: those under 45 and those 45 or over. Their analysis on this basis shows again underrepresentation in the VR program of those in the group 45 or over. *Assessing Age Discrimination*, p. 16.

Table 7.3

Percent Distribution of Persons Accepted for Vocational Rehabilitation Services By Age, Fiscal Year 1976, and the Disabled and Severely Disabled Populations by Age, Calendar Year 1972

Age Group	Disabled Population[a]	Severely Disabled Population[a]	Persons Accepted for VR Services Whose Cases Were Closed[b]
All Ages	100.0%	100.0%	100.0%
20-24	6.7	3.5	23.8
25-34	12.5	8.5	30.0
35-44	15.4	14.2	20.0
45-49	14.6	12.1	9.5
50-54	14.8	15.0	7.9
55-59	16.4	19.2	5.6
60-64	19.5	26.6	3.2

Source: [a] Kathryn H. Allan, "First Findings of the 1972 Survey of the Disabled: General Characteristics."

[b] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from the R-300 File for Fiscal Year 1976. Age is reported at the time of referral to the VR program.

Table 7.4

Percent Distribution of Persons Accepted For Vocational Rehabilitation Services By Age, Fiscal Year 1976, and the Disabled Population in the Labor Force by Age, Calendar Year 1972

Age Group	Disabled Population in the Labor Force in 1972[a]	Persons Accepted for VR Services Whose Cases Were Closed in FY 1976[b]
All Ages	100.0%	100.0%
20-34	25.2	53.8
35-44	17.3	20.0
45-54	31.0	17.4
55-64	26.4	8.8

Source: [a] U.S., Department of Health, Education, and Welfare, Social Security Administration, unpublished data from the 1972 Survey of the Disabled.

[b] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from the R-300 File for Fiscal Year 1976. Age is reported at the time of referral to the VR program.

detailed picture of age participation patterns in the VR program. Individuals who were 60 to 64 and 65 or older exhibit higher percentages of successful rehabilitations. This factor suggests that clients aged 60 or over who gain entry to the program have successful rehabilitation rates that compare favorably with those of younger age groups. Persons aged 50 to 54 and 55 to 59, on the other hand, do not exhibit as strong a successful rehabilitation rate. This may be explained by the high proportions, 41.2 percent and 39.6 percent, in which those groups are closed at the referral stage. Combined with those who are closed at the applicant stage, nearly two-thirds of those reported in these age groups did not receive any case services. The percentages of each age group between 40 and 59 who are successfully rehabilitated are lower than other groups, but they are not substantially lower than those for the groups from 25 to 39. (See table 7.5.)

Data collected through the R-300 reports include all persons who had cases opened by a VR agency; that is, there was some contact or referral that supplied minimum identifying information on the individuals. Data on all VR cases opened (referrals) were reviewed to determine the age distribution of persons who come into contact with the VR program. Data for fiscal years 1974 and 1976 show slight variations in the percentage of referrals by different age groups, but no significant changes occurred for any age. The mean and the median ages of referrals remained nearly constant. The mean age was about 33 or approximately 1 year older than for VR clients who were successfully rehabilitated. For both fiscal years, approximately 20 percent of all referrals were 19 or

Table 7.5
Percent Distribution of An Individual's Status When the Vocational Rehabilitation Case Was Closed by Age, Fiscal Year 1976

	Status When Case Was Closed				
Age At Referral/100%	Referral	Applicant	Extended Evaluation	Successful Rehabilitation	No Rehabilitation
All Ages	23.8%	30.3%	1.7%	27.9%	16.3%
Under 20	11.4	32.3	2.1	33.2	21.0
20-24	16.2	35.4	1.7	28.1	18.5
25-29	20.0	33.8	1.7	27.2	17.3
30-34	23.0	31.4	1.7	27.4	16.5
35-39	26.8	29.1	1.7	26.7	15.6
40-44	32.1	27.0	1.6	25.0	14.4
45-49	36.4	25.5	1.6	23.4	13.0
50-54	41.2	24.1	1.4	22.0	11.2
55-59	39.6	23.2	1.4	25.0	10.7
60-64	29.5	22.6	1.5	35.7	10.7
65 or older	20.3	26.8	1.7	42.9	8.3

Source: U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from R-300 File for Fiscal Year 1976,

under, and more than half were under 35. Furthermore, about 25 percent were 45 or older, less than 10 percent were 55 or older, and less than 2 percent were 65 or older. (See table 7.6.)

Those persons who had VR cases opened were compared to the disabled population to determine if age might be a factor in who was referred for VR services. As with persons who are accepted for VR services, the proportion of the referral population declines with age, while the proportions of the disabled and severely disabled populations increase with age. Nearly two-thirds of the disabled population is 45 to 64 years old, but two-thirds of the VR referrals were between 20 and 44 in each year. Thus, the problem with underrepresentation of persons 45 or over in the VR program seems to occur at or before the entry point into the program. Persons 45 or older do not appear in the population referred to VR agencies for determination of eligibility in the proportions they represent in the disabled population. (See table 7.7)

The reasons why persons were rejected for VR case services were reviewed for persons whose cases were closed at the referral or applicant status in fiscal year 1974. The most stiking differences among the reasons for rejecting persons of different age groups occur in the category of "disability too severe." Although only 3.5 percent of those under 20 were rejected because their disability was considered too severe, approximately 20 percent of those in each age category of the 50 or older group were rejected for this reason. Persons 50 or older were 62.9 percent of all persons rejected because of severity. (See table 7.8.)

Table 7.6

Percent Distribution of All Persons Referred to the Vocational Rehabilitation Agencies by Age, Fiscal Years 1974 and 1976

Age At Referral	Persons Referred Whose Cases Were Closed in FY 1974	Persons Referred Whose Cases Were Closed in FY 1976
All Ages	100.0%	100.0%
Under 20	20.9	19.8
20-24	16.6	16.8
25-34	20.1	22.3
35-44	15.9	16.1
45-54	16.8	16.3
55-64	8.3	7.5
65 or over	1.4	1.3
Mean Age	33.4	33.2
Median Age	30.0	30.0

Source: U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from the R-300 File for Fiscal Years 1974 and 1976.

Table 7.7

Percent Distribution of Referrals for Vocational Rehabilitation Services by Age, Fiscal Years 1974 and 1976 and the Disabled Population by Age, Calendar Year 1972

Age Group	Disabled Population[a]	Persons Referred for VR Services, FY 1974[b]	Persons Referred for VR Services, FY 1976[b]
All Ages	100.0%	100.0%	100.0%
20-24	6.7	21.3	21.2
25-34	12.5	25.9	28.3
35-44	15.4	20.5	20.4
45-49	14.6	11.2	10.8
50-54	14.8	10.4	9.9
55-59	16.4	7.5	6.5
60-64	19.5	3.2	2.9

Source: [a] Kathryn H. Allan, "First Findings of the 1972 Survey of the Disabled: General Characteristics."

[b] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from the R-300 File for Fiscal Years 1974 and 1976.

Table 7.8

Percent Distribution of Persons Whose Cases Were Closed and Applicant Statuses by Age by the Reason for Rejection, Fiscal Year 1974

Age At Referral/ 100%	Reason for Rejection			
	Disability Too Severe	Disability Not Severe Enough	Client Failed To Cooperate[a]	Other Reasons[b]
All Ages	13.2%	11.4%	40.3%	35.2%
Under 20	3.5	19.1	45.2	32.2
20-34	8.0	11.7	40.5	39.8
35-49	17.2	8.7	39.5	34.5
50-59	24.5	7.9	36.9	30.7
60-64	22.4	9.4	38.6	29.6
65 or over	16.0	12.4	39.4	32.2

[a] Includes clients who refused services.

[b] Other reasons include death, client institutionalization, transfefred to other agency, could not be located, and other.

Source: U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, 10 percent sample of all case closures from referral or applicant status from the R-300 File for Fiscal Year 1974, tabulated by the Urban Institute for the U.S. Commission on Civil Rights.

Older age groups do account for a higher percentage of the severely disabled population. However, the *Report of the Comprehensive Needs Study*, a study of the VR program conducted by the Urban Institute and sponsored by the Department of Health, Education, and Welfare, challenged the validity of VR counselors' rejecting older persons for "severity of disability." As part of its study, the Urban Institute interviewed a sample of 889 individuals who were rejected because their disabilities were determined to be too severe. The Urban Institute determined the degree of disability for these individuals using, among other measures, the "Barthel Index" which determines whether an individual can perform certain specified tasks without assistance from other persons. The institute concluded in its report:

> . . .most people rejected for severity can perform almost all activities of daily living (ADL) and perform them without difficulty. Only two of the 11 items (lifting weights of 10 pounds or "stooping, bending or kneeling") were either impossible or difficult for a majority of people in [the] sample.[40]

The Comprehensive Needs Study also indicated that frequently the older respondents (those over 30) who were rejected for severity were not, in fact, severely dependent. Among the rejected persons interviewed, the percentage of those who were totally or severely dependent, in fact, decreased as age increased. Among the respondents aged 16 to 30, 43 percent were determined to be totally or severely dependent; those aged 31 to 40, 14 percent; those aged 41 to 50, 8 percent; those aged 51 to 60, 4 percent; for those aged 61 or older, 8 percent.[41] The study concluded further:

> From the data, it appears that age is an important reason for rejection—i.e., a sizeable portion of the young are actually rejected for severity while older persons are rejected for other reasons, perhaps because they cannot as readily be trained or placed in jobs as younger persons with similar physical problems.[42]

Data on the type of placement of successfully rehabilitated VR clients to determine if age might have an effect on the type of placement goal developed by the counselor and the handicapped individual were reviewed. The placement categories were competitive employment, noncompetitive employment (including sheltered workshops, unpaid family workers, and others), and homemaker. It was clear from this review that homemaker placements are higher for older age groups while competitive employment placements are lower. One explanation of the data may be that older VR clients—those 50 or over—are not provided with services necessary to produce rates of competitive closures equal to those of the younger age groups. On the other hand, as an Urban Institute study conducted for the Commission suggested, there might "exist a greater need for and a greater value to homemaker closures in older age groups."[43] Restoring a person to homemaker status might produce, for example,

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[40] *Comprehensive Needs Study*, p. 130.

[41] Ibid., p. 132.

[42] Ibid., p. 133.

[43] *Assessing Age Discrimination*, p. 37.

Table 7.9

Percent Distribution of Rehabilitated Vocational Rehabilitation Clients by Age and by Type of Placement, Fiscal Year 1974

Age At Referral	Competitive Employment	Non-Competitive Employment[a]	Homemaker
All Ages	80.9%	4.2%	14.9%
Under 19	88.4	4.2	7.4
20-34	85.3	4.2	10.4
35-49	76.7	4.2	19.1
50-59	66.8	4.3	28.9
60-64	57.8	3.4	38.8
65 or over	40.2	3.8	56.0

[a] Unpaid family workers were included in the non-competitive employment category.

Source: U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, 10 percent sample of the R-300 File for Fiscal Year 1974, tabulated by the Urban Institute for the U.S. Commission on Civil Rights.

an important incidental benefit of preventing institutionalization. (See table 7.9)

In summary, review of the program data showed that persons 45 or older were consistently underrepresented for VR services when compared with the disabled population, the severely disabled population, or the disabled population in the labor force, and that the disparities increase by successive age groups. Successful rehabilitation rates for age groups 60 to 64 and 65 or older are actually higher than for the younger groups. Although the successful rehabilitation rates for age groups between 40 and 59 are lower than those for younger and older groups, they are not substantially lower than for those 25 to 39. Thus, for those older (45+) disabled who enter the VR program, the ability to be successfully rehabilitated does not appear to be a major problem. The point where age appears to be the most serious barrier to participation is at gaining entrance into the program, as demonstrated by the age composition of the total population referred for VR services.

Interpretation of the Goal of Gainful Employment

The statutory goal of the vocational rehabilitation program is to provide services to rehabilitate handicapped individuals so they may engage in gainful employment. Although stating that "gainful employment" is the goal, the law does not define the term. It ties eligiblity to whether a person can be reasonably expected to benefit in terms of "employability," which Federal regulations define as the prospect that someone will be able to work in competitive employment or in a sheltered workshop (noncompetitive employment) or as a homemaker or in "other gainful work."

Both the Congress and the Department of Health, Education, and Welfare have stressed placement of clients in competitive employment as opposed to the other employability categories. For example, the statute requires a State to review persons placed in employment in rehabilitation facilities (including sheltered workshops) with the aim of moving them into the competitive labor market when feasible.[44] A report of the Senate Committee on Labor and Public Welfare suggests that workshops should not be "a substitute for employment."[45] In another report, the House Committee on Education and Labor commented on the statutory priority placed on the severely disabled in the Rehabilitation Act of 1973:

> . . .it is the Committee's intent that funds for basic services also be used to provide services for those individuals with severe handicaps who can benefit from the services provided and be placed in competitive employment.[46]

Evaluation standards issued by the Department of Health, Education, and Welfare for State VR agencies specify higher performance levels for competitive employment than for other types of placement. The level for competitive employment for general VR agencies (excluding agencies administering programs for the blind) is set at "not less than 70 percent" of all placements.[47] The term "gainful employment" has been interpreted by some State and local administrators as employment in the competitive labor market. This interpretation, coupled with serious difficulties in placing persons 45 or over in the competitive labor market, was reported to cause VR counselors to "be cautious" about accepting older persons as clients.[48] VR program officials in two States used the terms "gainful employment" or "successful rehabilitation" when referring to placements in competitive employment.[49]

The VR program's emphasis on competitive employment placements, combined with a difficult job market for persons of certain ages, restricts practical application of the goal of "reasonable expectation for gainful employment" to disabled persons under age 45. (See the discussion on reliance on public and private employment markets later in this chapter.)

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[44] 29 U.S.C. §721(a)(16) (Supp. V 1975).

[45] *Report on Rehabilitation Act of 1972*, p. 23.

[46] U.S., Congress, House, Committee on Education and Labor, *Rehabilitation Act of 1973*, 93d Cong., 1st sess., 1973, H. Rept. 244, p. 10.

[47] Marshall Magee, deputy director, Mississippi Division of Vocational Rehabilitation, interview in Jackson, Miss., Apr. 28, 1977 (hereafter cited as Magee Interview); Laurence Deaver, regional representative, Federal Office of Rehabilitation Services, interview in Dallas, Tex., May 3, 1977 (hereafter cited as Deaver Interview); Vernon Interview; Botten Interview; and Sander Darbonne and Robert Magrady, counselors, interview in Chicago, Ill., May 19, 1977 (hereafter cited as Darbonne-Magrady Interview).

[48] 45 C.F.R. §1370.5(a)(2)(i) (1976).

[49] Jess Irwin, Jr., commissioner, Texas Rehabilitation Commission, interview in Austin, Tex., Apr. 25, 1977 (hereafter cited as Irwin Interview); Royce Vernon, Deputy Director, Federal Regional Office of Rehabilitation Services, interview in Dallas, Tex., May 3, 1977 (hereafter cited as Vernon Interview); and Mel Botten, district administrator, Washington Division of Vocational Rehabilitation, accompanied by three staff members, interview in Everett, Wash., Apr. 26, 1977 (hereafter cited as Botten Interview).

Performance Standards

During the Commission's field study, VR program administrators reported that national evaluation standards on types of VR placements cause VR counselors to limit provision of services to older disabled persons who are considered unlikely to be placed in competitive employment. Since labor market conditions restrict the placement of older disabled persons in competitive positions, counselors reported that the acceptance of older disabled persons as clients is risky, because the counselors must meet the quota for competitive placements specified in the evaluation standards.

The Rehabilitation Act of 1973 directs the Secretary of Health, Education, and Welfare to develop reporting and evaluation procedures to determine program and project effectiveness in achieving the statutory goals. The Secretary was required to publish general standards for evaluating programs and projects and to consider the extent to which such standards have been met in deciding whether to renew or supplement financial assistance authorized under any section of the act.[50]

The legislative history on this point is somewhat ambiguous about exactly what kinds of standards were intended and what areas of program operation were to be covered. The report of the Senate Committee on Labor and Public Welfare that accompanied the bill included a discussion of the reporting and evaluation provisions specified in the law, which included the requirement that standards be established. The discussion identified certain areas where the Committee wanted information.[51] Those areas were used as a guide for the development of the evaluation standards.[52]

Federal regulations containing the specific evaluation standards were published by the Secretary on December 19, 1975.[53] One of the standards specified percentages for the different types of placements "to insure that rehabilitated clients are placed in gainful employment suitable to their capabilities." For general VR agencies the standards are *not less* than 70 percent of placements in competitive employment, *not more* than 6 percent in noncompetitive employment, *not more* than 18 percent as homemaker, and *not more* than 4 percent as unpaid family workers. Different levels are specified for agencies administering programs for the blind—40 percent for competitive employment, 12 percent in noncompetitive employment, 42 percent as homemakers, and 7 percent as unpaid family workers.[54]

For the general agencies especially, these levels clearly stress competitive employment placements, even by the manner in which they are stated. The competitive employment placements are specified as a lower limit, while the other categories are upper limits. A Federal VR official in Atlanta claimed that because of its wording, the standard has been interpreted by States to mean that a State was not only required to have a minimum of 70 percent of its placements in competitive employment, but also that such placements should, in fact, constitute a higher percentage, perhaps 80 percent of all placement closures.[55]

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[50] 29 U.S.C. §781(b) (Supp. V 1975).

[51] *Report on Rehabilitation Act of 1972*, pp. 41–43.

[52] Jerry S. Turem and others, *Final Report on the Performance Standards of the Vocational Rehabilitation Program*, prepared for the Department of Health, Education, and Welfare (Washington, D.C.: The Urban Institute, 1976), pp. 3–5 (hereafter cited as *Performance Standards*).

[53] 45 C.F.R. §§1370.1–1370.5 (1976).

[54] 45 C.F.R. §1370.5(a)(2) (1976).

The placement standard does not account for variations that occur because of client characteristics. The one exception concerns the different performance levels for general agencies and for blind agencies. This was noted in an Urban Institute study, *Final Report on the Performance Standards*, prepared for the Department of Health, Education, and Welfare:

> Given this need to differentiate between blind and other clients it is not clear why the standard makes no attempt to recognize other clients who like the blind are more difficult to rehabilitate than the average client. Certainly if blind agencies are to be evaluated using lower minimal performance levels, general or combined agencies which serve a disproportionate share of recognizably more difficult clients should be provided similar consideration.[56]

The Urban Institute also pointed out the client characteristics that "appear to be important determinants of successful rehabilitation outcomes": type of disability, age, sex, race, and education.[57]

By not accounting for differences among clients or impediments outside their control, such as the unemployment rate, the placement standard makes no allowance for problems that may be peculiar to certain age groups, for example, age discrimination in employment, or the fact that older disabled women may be homemakers by profession and require assistance to maintain that gainful occupation. VR program data show that competitive placements decline with age as contrasted to homemaker placements, which increase with age. Among those 65 or over who were rehabilitated in fiscal year 1976, 60 percent were homemakers. Among younger age groups, placement in that category accounted for 7 percent for those under 19 and 34 percent for persons 50 to 64.[58] Thus, by trying to meet the placement levels specified in the standard, counselors can indirectly be discouraged from accepting cases that will result in homemaker placements.

The Assistant Commissioner for Program Management of the Rehabilitation Services Administration informed Commission staff that one reason for the relatively low performance level set for homemaker placments was to control the inappropriate use of that type of closure.

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[55] Martha Carrick, regional representative, Federal Office of Rehabilitation Services, interview in Atlanta, Ga., May 6, 1977 (hereafter cited as Carrick Interview).

[56] Turem, *Performance Standards*, appendix A, p. 5.

[57] Ibid., p. 86.

[58] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from a 25 percent sample of the R–300 file for fiscal year 1976. Special tabulations and analysis were performed by Commission staff.

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He indicated that, in the past, use of the homemaker closure had been abused when the services provided were inappropriate for a homemaker placement. He claimed that counselors would close a case as a homemaker when the competitive employment goal had not been achieved but placement was feasible for the client. The counselor might close a difficult case in this way to avoid having to do any more work on it. The case was then counted as a successfully rehabilitated closure instead of a case closed but not rehabilitated. Thus, according to the Assistant Commissioner, the statistics would look better. The low level set for homemaker placements in the standards was intended to curtail further abuse.[59] Nonetheless, a set level of such closures does not account for varying client characteristics, or necessarily "curbing abuse," but rather limits participation by certain persons who might otherwise be able to participate in the program.

Federal officials told Commission staff that the standards were "suggested standards," and that the Rehabilitation Services Administration would not compel all States to conform to the levels specified. They said that the standards were general goals against which States could assess their strengths and weaknesses.[60] The statute, however, requires the Secretary to determine how well a State is performing according to the standards in deciding whether to renew or supplement funding. The Federal regulations indicate that negotiations will take place with States that are found to be "more than one standard deviation from the mean" of the established standards before any action is taken by the Secretary.[61] A State or local program administrator could interpret the statute and Federal regulations to mean that the specified levels are mandatory to ensure further receipt of Federal funds.

Staff of VR agencies reported that, in some instances, the Federal performance standards had been interpreted as rigid quotas for the different placement categories and thus were influencing whom they would serve. This primarily affected services to older handicapped persons. The "low limit" placed on homemaker placements and the "high level" mandated for placements in competitive employment were the standards most frequently cited.

In Maine the percentage of homemaker placements was reported to be higher than the national average. A program specialist in the Boston Federal regional office said that Maine would have to "tighten up to meet the goal" of 14 percent.[62] The director of Maine's Bureau of Rehabilitation reported that counselors were accepting persons as clients with homemaker goals and providing them with hearing aids, glasses, or dentures. He said that such actions were "nice things to do," but that some of these cases were illegal and would have to be curtailed if the State was to reduce its homemaker cases to meet the standard.[63] On the other hand, counselors in Maine reported that they thought that all of the cases they designated for homemaker placement were legally eligible, so long as that placement was defined as a VR goal. They reported their belief that the State administrators were under pressure from the Federal regional office to get homemaker placements down to the "magic 14 percent," and in order to do this they were attempting "to cut back services to the elderly," whom they identified as the person most frequently closed in homemaker status.[64]

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[59] Fred Sachs, Assistant Commissioner for Program Management, Rehabilitation Services Administration, interview in Washington, D.C., Dec. 17, 1977.

[60] Ibid; and Fred Sachs, Miriam Stubbs, Don Rawe, and Tom Skelley, interview in Washington, D.C., July 20, 1977.

[61] 45 C.F.R. §1370.1(c) (1976).

[62] John Levis, rehabilitation services program specialist, interview in Boston, Mass., May 27, 1977. It should be noted that the national performance level for homemaker closures was cited as 14 percent instead of 18 percent as set forth in the Federal regulations.

A Federal official in Atlanta reported that, in her opinion, placement levels set by the evaluation standards had caused counselors to curtail services to the elderly. She said that most VR services provided to individuals in their sixties and seventies had been surgery and prostheses or appliances, and such cases had usually been closed in the past as homemaker placements. With the advent of national standards, counselors were strongly encouraged to close at least 70 percent of their cases as competitive employment cases. She reported that counselors believed that they had to cut back on the provision of services to older persons, since most of those cases were classified as homemakers. She commented that counselors found the standards very discouraging and they were bitter because they felt they had no latitude. She claimed that as more pressure was placed on local VR agencies to meet the performance levels, counselors would reduce the number of older persons accepted for services. Although the first group to "fall out," she said, would be the elderly, she thought reaction to the standards might even affect services to those 45 years old.[65]

Although a low level of homemaker placements may have been set in an attempt to curb past abuses in using that closure, the mere imposition of a ceiling on the allowable percentage of such placements does not solve the problem. And even though Federal staff say that levels set in the standards are only "suggested levels," the standards threaten the application of sanctions if a State does not perform within "one standard deviation" of the established levels. Whether or not the Department of Health, Education, and Welfare acts on its authority assumed in the statute and regulations is not relevant. The standards constitute Federal requirements that a State must follow. Except for different levels set for agencies that serve the blind exclusively, the standards do not account for any variation in client characteristics that might influence the type of placements that would be appropriate. As reported to Commission staff, the lack of flexible standards based on caseload composition and the interpretation of the placement standards as required quotas affects service, predominantly to older disabled persons who, in this case, might be defined as persons 45 or over.

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[63] C. Owen Pollard, director, Bureau of Rehabilitation, interview in Augusta, Me., May 25, 1977 (hereafter cited as Pollard Interview).

[64] Frank Rowe, Bob Horn, Jim Gorman, counselors, interview in Rockland, Me., May 25, 1977 (hereafter cited as Rowe Interview).

[65] Carrick Interview.

Program Policies and Practices

The statute and Federal regulations governing the VR program leave certain decisions concerning program operations to the discretion of the State agencies. For example, the statute defines the basic criteria for program eligibility; however, States have established additional criteria that affect the composition of the participant population. Federal regulations prohibit age discrimination in applying the program's eligibility requirements or by establishing upper or lower age limits on eligibility.[66] Nevertheless, age was a factor in the eligibility policies in five States visited by Commission staff.

The Texas State rehabilitation manual states that if an individual under 16 years of age is accepted for vocational rehabilitation services, it must be determined that the individual will be of working age "when the rehabilitation effort is to be completed."[67] The director of the Texas Rehabilitation Commission said that this policy is due to child labor and other related laws.[68]

An information brochure published by the Missouri Division of Vocational Rehabilitation states:

> There is no set age limitation. As a practical matter, though, persons served are those who are normally considered to be of an employable age. As a result, the great majority of Vocational Rehabilitation clients would fall into the age range of from 16 through 65.[69]

A district supervisor in Missouri said that if a disabled person is under 16, there is little the VR agency can do for him or her. He added that "if an applicant is close to his 16th birthday, VR may provide training."[70] The Missouri State Agency on Aging reported receiving a complaint about the VR program: someone had alleged that he was told over the telephone that VR served those of normal working age and that a 65-year-old person would not qualify for services.[71]

It was reported that Maine has a policy of not taking cases under age 14, since no occupational objective could normally be determined at that time. The school system was said to be "responsible for providing the necessary services to that age group." VR counselors in Maine maintained that schools do little, if anything, for disabled children, and by the time they reach 14, the psychological, emotional, and physical problems are so numerous and complex that rehabilitation is often impossible or is more expensive than it need be. The counselors argued that in the long run it would be cheaper and more productive to serve children earlier.[72]

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[66] 45 C.F.R. §1361.33(a) (1976).

[67] Texas Rehabilitation Commission, *Rehabilitation Services Manual*, no. 02-4, Feb. 1, 1977 (rev.), p. 16.

[68] Irwin Interview.

[69] State of Missouri, State Department of Elementary and Secondary Education, Division of Vocational Rehabilitation, "Vocational Rehabilitation in Missouri: The Answers to Some Questions."

[70] David Chance, district supervisor, Missouri Division of Vocational Rehabilitation, interview in Olivette, Mo., Apr. 4, 1977 (hereafter cited as Chance Interview).

[71] Don Erter, program coordinator, Missouri State Agency on Aging, interview in Jefferson City, Mo., Apr. 12, 1977.

The Mississippi *Manual of Policies* states: "The minimum age for acceptance is such that by the completion of a continuous program of vocational rehabilitation services, the client will have reached the age of employability."[73] A Federal regional official said that such a policy means that VR counselors usually start considering disabled people for services who are "around 16 years of age."[74] The Mississippi manual also contains a statement on the maximum age requirements:

> The individual, regardless of age, may be accepted for service if his general physical or mental condition is such that he can become employable as a result of the service, and can be expected to remain in employment a sufficient length of time to justify the expenditures for his rehabilitation.[75]

Counselors must consider these criteria when screening persons at the upper end of the normal working age—meaning in the State, near 65. This policy penalizes those approaching this age boundary as well as those beyond it.

The California Department of Rehabilitation submitted to the Commission a policy statement, "Age as a Factor in Rehabilitation." According to the statement, no minimum age is involved in determining eligibility for vocational rehabilitation services; however, the State follows a general principal that the client should be able to enter employment following completion of services. The statement says further that "older applicants should not be accepted for services if they would be beyond employable age at completion of services."[76] The statement fails to define "employable age." When asked to interpret this phrase, Betty Dieckman of the California Department of Rehabilitation testified that no precise definition exists, but the experience of most counselors would indicate that 65 is the maximum employable age.[77]

The California department's policy statement also points out age-related factors that affect placement:

> (1) employer attitudes toward age affect the individual's placeability; (2) age plus disability is an increased risk to employers; (3) mandatory retirement ages and pension plans restrict employable age; and (4) labor unions counsel people to take pensions to make room for younger workers.[78]

Thus, emphasis on employability, as identified in these five States, can result in discrimination because such policies discourage counselors from accepting into the program persons who are not within the ages commonly accepted as the boundaries of the labor market. Sometimes persons *approaching* the upper age boundary are also penalized.

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[72] Rowe Interview.

[73] State of Mississippi, Division of Vocational Rehabilitation, *Manual of Policies*, January 1976, p. II-2-4 (hereafter cited as *Mississippi Manual*).

[74] Carrick Interview.

[75] *Mississippi Manual*, p. II-2-4.

[76] Betty Dieckman, California Department of Rehabilitation, "Age as a Factor in Rehabilitaton," paper submitted to the Commission, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27-28, 1977, vol. II. (hereafter cited as *San Francisco Hearing*).

[77] Dieckman Testimony, *San Francisco Hearing*, vol. I, p. 80.

[78] Dieckman, "Age as a Factor," *San Francisco Hearing*, vol. II.

Outreach and Referral Activities

Examination of national data indicated that age disparities between the disabled population and VR clients begins at or before the time of entry into the program; disabled persons 45 or older are not entering the program in proportion to their representation in the disabled or severely disabled populations. The field study revealed two interrelated problems that affect program entry—the lack of outreach and the reliance on referral sources that do not adequately reach all age groups. Referral sources are usually those individuals, agencies, or organizations who come in contact with disabled individuals. For the most part, these sources are agencies or individuals that serve the population of all ages—welfare or other public agencies, physicians, health and mental health agencies, and hospitals; however, another frequently used source is educational institutions.[79]

Most VR agencies visited by Commission staff reported no formal outreach activitites. Efforts to inform potentially eligible persons of the VR program were reported to be primarily the responsibility of individual counselors who work with and rely on referral sources.[80] When such arrangements work well, they can be an effective method for matching eligible persons with needed services. Reliance on referral sources is a problem, however, when too few or no sources exist that might refer persons in certain age groups. Also, some sources prescreen individuals and may be eliminating older applicants. Referral sources are the primary access point to VR services for disabled persons. Persons who have been referred for services have indicated that, although disabled, they had been unaware of the VR program until the referral source had mentioned the available services.[81] Since referral sources are the predominant way that disabled individuals learn of the services, they should be available so that all age groups have access to them.

In Illinois, Texas, Washington, and Florida, VR program administrators specifically mentioned that their referral sources primarily emphasized younger individuals.[82] In fact, in Washington local staff reported that a "conscious effort" had been made not to expand referral activities into senior citizen centers and nursing homes.[83] The restriction on homemaker placements coupled with certain notions about other employability of nursing home residents may explain the decision insofar as nursing homes are concerned; however, senior citizens centers might serve persons in the eligible population, and they are often viewed as information centers by their participants.

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[79] Cranston Mitchell, counselor, Division of Vocational Rehabilitation, interview in Olivette, Mo., Apr. 5, 1977 (hereafter cited as Mitchell Interview); Chance Interview; and John Fenoglio, director, general programs, and Jimmy Jackson, director, special programs, Texas Rehabilitation Commission, interview in Austin, Tex., Apr. 26, 1977 (hereafter cited as Fenoglio-Jackson Interview).

[80] Magee Interview; Fenoglio-Jackson Interview; and Elmer W. Nelson, district supervisor, Missouri Division of Vocational Rehabilitation, interview in St. Louis, Mo., Apr. 4, 1977 (hereafter cited as Nelson Interview).

[81] Mitchell Interview.

[82] Evans Ronshausen, regional administrator, interview in Chicago, Ill., May 19, 1977 (hereafter cited as Ronshausen Interview); Howard Marnan, supervisor district office, Texas Rehabilitation Commission, interview in San Antonio, Tex., Apr. 29, 1977 (hereafter cited as Marnan Interview); Botten Interview; and Wayne Thornberry, program supervisor, Florida Office of Vocational Rehabilitation, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida,* Aug.

While most referral sources are in contact with persons of all ages, educational institutions primarily serve those in the younger age groups. Schools are the only age-based referral source specified in national program data, accounting for 10 percent of all referrals in fiscal year 1976.[84] Although some VR counselors may use other age-based referral sources, the school category appears to be the only age-based source large enough to justify separate data tabulations.

Table 7.10 presents data on referral source by age group for fiscal year 1974. Referrals from educational institutions accounted for 11.6 percent of referrals for all age groups. The older age group, not surprisingly, had a negligible proportion of referrals from this source; 45.7 percent of the referrals from educational institutions were under 20. A larger proportion of middle-aged and older referrals came from social service and public welfare agencies. Disabled individuals 60 or over were most frequently referred by physicians and other individuals or were self-referred.

In Texas and Florida, State VR staff reported having "cooperative school programs" that stress early referrals to VR for services. Wayne Thornberry, program supervisor of the Florida Office of Vocational Rehabilitation Services, testified that one reason for such a strong referral program in the schools was the VR program's focus on serving the handicapped individual "earlier in life" rather than later.[85] In Texas, which also had a cooperative school program, it was reported that younger clients had better access to VR services than middle-aged and older persons, who did not have a comparable referral institution. The State director of special programs said that middle-aged disabled persons had fewer community contacts with referral sources than either younger or older persons, because they did not frequent the "usual" access sources for the service system.[86]

As stated above, an additional problem related to referral sources is that some prescreen disabled persons; that is, the referral sources apply some criteria and determine which disabled persons to refer and which not to refer for VR services. Such prescreening allows a referral source to make its own eligibility determination, at least for those persons not referred to VR services. Age appears to be an important consideration in these decisions to

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22–23, 1977, vol. I., pp. 27–28 (hereafter cited as *Miami Hearing*).

[83] Botten Interview.

[84] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, unpublished data from a 25 percent sample of the R–300 file for fiscal year 1976. Special tabulation and analysis by Commission staff.

[85] Thornberry Testimony, *Miami Hearing*, pp. 27–28.

[86] Fenoglio-Jackson Interview.

Table 7.10
Percent Distribution of Persons Referred for Vocational Rehabilitation Services by Age and Source Of Referral, Fiscal Year 1974

	Referral Source				
Age At Referral/ 100%	Educational Institutions	Health and Hospital Institutions	Social Services And Welfare Agencies	Self-Referrals	Physicians and Other Individuals
Total Cases	11.6%	16.2%	48.5%	10.6%	13.1%
Under 20	45.7	8.9	29.0	5.4	11.0
20-24	6.7	16.9	45.7	14.6	16.2
25-29	3.0	19.6	49.3	13.4	14.8
30-34	1.9	19.9	51.6	12.9	13.6
35-39	1.5	20.0	54.3	11.3	12.9
40-44	1.1	19.1	57.7	10.6	11.4
45-49	0.7	17.4	61.1	9.8	11.1
50-54	0.7	14.9	64.6	8.8	10.9
55-59	0.7	15.4	62.5	9.3	12.1
60-64	0.7	20.3	46.4	12.8	19.8
65 or older	2.8	24.9	36.7	14.9	20.7

Source: U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, 10 percent sample of the R-300 File for Fiscal Year 1974, tabulated by the Urban Institute for the U.S. Commission on Civil Righs.

refer individuals to the VR agency. For example, Illinois had a very low referral rate for older persons; in fiscal year 1976, only 6 percent of all referrals were persons 55 or over.[87] A regional administrator for the Illinois Division of Vocational Rehabilitation reported that the older disabled are not referred to the VR agency so "someone out there" must be screening them out.[88]

The disability determination unit of the Missouri Division of Family Services not only determined whether a person was eligible for medical and social services, but also decided whether or not to refer an individual to the VR agency. The unit's medical social worker reported that they did not refer persons they determined were unable to be rehabilitated. She said that age is a significant consideration in whether they refer an individual for VR services.[89]

In addition to the reliance on referral sources, several other reasons were reported for the lack of outreach activities by VR agencies. For example, the Illinois VR agency has a very full caseload and it was asserted that no need existed "to go beat the bushes" for other clients.[90] Even though only 6 percent of all their referrals

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[87] State of Illinois, Division of Vocational Rehabilitation, unpublished data (in Commission files).

[88] Robert Smith, regional administrator, Illinois Division of Vocational Rehabilitation, interview in Chicago, Ill., May 20, 1977 (hereafter cited as Smith Interview).

[89] Anne Dintelmann, medical social worker, Missouri Division of Family Services, interview in St. Louis, Mo., Apr. 4, 1977.

[90] Marlene Nelson, administrative assistant to the director, Illinois Division of Vocational Rehabilitation, interview in Chicago, Ill., May 19, 1977.

are 55 or older, program administrators did not seem to view outreach as a tool to reach those segments of the eligible population that were not coming into the program.

Missouri officials explained that they were able to serve all eligible applicants because of the Federal and State funding increases over the past few years.[91] In fact, the State had actually returned Federal funds for "the last year or so."[92] However, the State was not conducting an active outreach program to located disabled persons who would be eligible for the service. A district supervisor claimed that there was no need for outreach activities because "VR knows who the disabled are." He also said there was not enough money or staff to undertake a formal outreach program.[93]

In Missouri, Washington, and Texas, VR staff reported that their programs were not reaching all eligible persons. The reason offered was that if a disabled person was not in contact with one of the referral sources, it was unlikely that he or she would reach the program.[94]

The director of the Maine Bureau of Rehabilitation estimated that 30,000 persons in the State are eligible for VR services but said that only 8,000 are being served. He also said that those referred to and served by the program are more often younger than older. He maintained that everyone who is referred can be served by the program, and yet there is no active outreach component to reach the remaining 24,000 estimated eligible individuals.[95]

In two States, however, individuals described previous media efforts they viewed as unsuccessful. In Missouri two district supervisors said that a national media campaign run by the Rehabilitation Services Administration in 1972 or 1973 had included television announcements of the VR program's existence. The result had been a flurry of applications from people who misunderstood the announcement, they said, and the people who came to the VR agencies "were not seriously interested in working but were looking for a handout." One supervisor said he did not view the media approach as successful or efficient because too much staff time was needed to follow up on the influx of new inquiries.[96]

In Texas a public relations firm had been hired to advertise rehabilitation services. Two program administrators reported that the service had been stopped in 1976, when funds were no longer available and the agency had reached a full caseload of clients. The State director of special programs said that, in his view, the use of the media was not an effective outreach method because out of every 10 individuals who came in as a result, perhaps only 1 or 2 were actually eligible.[97]

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[91] William Keith, assistant commissioner, Missouri Division of Vocational Rehabilitation, interview in Jefferson City, Mo., Apr. 11, 1977.

[92] George Kester, Director, Federal Regional Office of Rehabilitation Services, interview in Kansas City, Mo., Apr. 15, 1977.

[93] Chance Interview.

[94] Mitchell Interview; Peter Jamero, director, Washington Division of Vocational Rehabilitation, interview in Olympia, Wash., Apr. 27, 1977 (hereafter cited as Jamero Interview); and Fenoglio-Jackson Interview.

[95] Pollard Interview.

[96] Nelson Interview.

Nevertheless, the reported outreach activities were effective in notifying individuals of VR services and getting interested individuals to contact the agency. In fact, their effectiveness in bringing persons into the agency caused the complaints of the program administrators. If too many ineligible persons came to the VR agency as a result of the advertisements, it could be an indication that the announcements needed to be clearer, not that the outreach approach was ineffective in reaching people. That public advertising brings more people into contact with the VR agency was further attested to in Texas. The Epilepsy Foundation had conducted a television advertising campaign that reportedly resulted in increased numbers of self-referrals by epileptics to the VR program. Texas VR staff did not complain that these were ineligible persons.[98]

More than half of all referrals are under the age of 35. The underrepresentation of persons 45 or older in the VR program in comparison to the disabled population begins at the referral stage. Active outreach activities were not reported in most of the States visited, and the lack of such activities, especially any activities aimed at the underrepresented groups, offers no chance for changing the referral pattern. Similarly, the lack of age-based referral sources for the older disabled population perpetuates or, at least, does not offer a constructive means to change the age distribution within the program.

Reliance on Public and Private Employment Markets

The emphasis on competitive employment in the VR program means that its success is largely tied to the employment market. To the extent that age discrimination exists in the labor market, it affects the ability of certain age groups to participate in the VR program where success of an agency is measured by its ability to rehabiliate clients and place them in competitive employment.

The Age Discrimination in Employment Act of 1967,[99] which applies to most employers, bans age discrimination in employment against persons between the ages of 40 and 65; however, it was reported that discrimination on the basis of age in employment continues to be a problem.

In eight of the sites visited by Commission staff, VR administrators and counselors said that problems associated with serving older handicapped persons stem from the continued existence of age discrimination in the employment market.[100] In the State of Washington, a district administrator said that the job market is better for persons between 20 and 45 than for those over 45.[101] A regional director with the Maine Bureau of Rehabilitation indicated that because of job market pressures for "younger" workers, their competitive employment closures were, for the most part, under 40 years of age.[102] The manager of the operations unit of the agency claimed that there was great difficulty getting a job for a 40-year-old person, especially if disabled.[103] A supervisor in a district office of the Texas Rehabilitation Commission reported that clients aged 50 or older are "hard to sell" to an employer.[104] In Mississippi, a VR counselor said that mandatory retirement policies affect the ability of persons 65 or older to locate employment: "Sixty five in the minds of a lot of folks is a magic number. We all know people could go on past 65, but employers have age policies."[105]

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[97] Fenoglio-Jackson Interview.

[98] Leo Garza, supervisor, interview in San Antonio, Tex., May 2, 1977 (hereafter cited as Garza Interview).

[99] Age Discrimination in Employment Act of 1967, Pub. L. No. 90-202, 81 Stat. 602 [codified at 29 U.S.C. §§621-634 (1970)].

[100] Marilyn McInnis, manager, operations unit, Maine Bureau of Rehabilitation, interview in Augusta, Me., May 25, 1977 (hereafter cited as McInnis Interview); Richard Becker, public information specialist, interview in Jefferson City, Mo., Apr. 11, 1977; Botten Interview; Marnan Interview; Deaver Interview; Vernon Interview; Bill Watson, counselor, interview in Jackson, Miss.,

An employment specialist in Texas reported that employers rarely, if ever, told them that age was the reason for not employing an individual, but older referrals were the ones who came back not hired. He said that his experience was that employers did consider age as well as disability in deciding whom they would hire. He claimed that age entered into the decision mainly because it was visible when someone went in for an interview. He reported that he has had several instances when employers have "point blank said that they don't want someone that old."[106]

The Deputy Director of the Federal Office of Rehabilitation Services in Dallas reported that the combination of age and handicap constitutes a double barrier to employment.[107] Wayne Thornberry, a program supervisor for the Florida Office of Vocational Rehabilitation described the same problem in this manner: "It has been difficult to convince business to hire the handicapped. It is doubly difficult to convince them to hire the elderly handicapped."[108]

The Acting Regional Director of the Federal Office of Rehabilitation Services in Seattle disagreed with reports that it is difficult to place older clients and said he believed that older VR clients were easier to place because of their experience. In his opinion, if counselors are willing to get training for clients, there are a lot of employment opportunities.[109]

In six of nine States, VR program staff said the major problem resulting from age discrimination in employment was the

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May 2, 1977 (hereafter cited as Watson Interview); Jerry Sawyer, vocational rehabilitation supervisor, interview in Jackson, Miss., Apr. 28, 1977 (hereafter cited as Sawyer Interview); Magee Interview; Darbonne-Magrady Interview; Thornberry Testimony, *Miami Hearing*, p. 28; and Ronald Kaminsky, district administrator, California Department of Rehabilitation, testimony, *San Francisco Hearing*, pp. 79–80; Mary Kathryn Brady, regional director, Maine Bureau of Rehabilitation, interview in Augusta, Me., May 23, 1977 (hereafter cited as Brady Interview).

[101] Botten Interview.

[102] Brady Interview.

[103] McInnis Interview.

[104] Marnan Interview.

[105] Watson Interview.

[106] Marnan Interview.

[107] Vernon Interview.

[108] Thornberry Testimony, *Miami Hearing*, p. 28.

[109] Issac Johnson, Acting Director, Federal Regional Office of Rehabilitation Services, interview in Seattle, Wash., May 5, 1977.

difficulty of placing older clients once they had been rehabilitated.[110] Dirk Schuurman, Deputy Regional Director of the Office of Rehabilitation Services in San Francisco, testified: "With increasing age, we find the phenomenon that it is much more difficult to, one, place an older worker, and, two, in particular an older worker with some kind of disability."[111]

In Illinois two counselors reported that because of discrimination in the labor market, placement specialists have become cautious in their handling of older persons. Since there is greater possibility of rejection from a job interview, older VR clients can easily become discouraged during the job search process. They said that placement specialists had to work with the client to maintain the client's interest, so that more individual time and attention was required for clients in their forties or older, especially to get a job paying a middle income or better.[112]

In its report that accompanied the Rehabilitation Act of 1973, the Senate Committee on Labor and Public Welfare recognized that some VR clients are more difficult to serve. In reference to the severely disabled the report stated: "The Committee is cognizant of the fact that it may take greater effort to set up a rehabilitation program for these individuals, and it fully expects rehabilitation counselors to make this effort."[113] The difficulty of a case, whether a severely disabled or older client, does not appear to be a justification for not serving individuals in such groups.

The time factor was not the only reason reported as to why placement specialists do not want to work with older clients. Two Illinois counselors stated that placement people discriminate on the basis of age because "they want to satisfy employers."[114] This occurs because specialists want and, for their continued success, need to satisfy employers.

It was reported that interpretation of the job market and its receptiveness to older persons can, in turn, negatively influence a counselor who is determining the feasibility of accepting a case.[115] Ronald Kaminsky, the district administrator of the California Department of Rehabilitation for San Francisco City and County, testified:

> . . .the jobs that would be available are so few and far between that the counselor would have to really exert a great deal of energy and disproportionate time in order to unearth those particular jobs. And the counselor needs to equate whether or not he can continue to be productive in doing that kind of needle in the haystack search.[116]

A Federal regional official in Dallas said he thought handicapped persons 65 or over had limited access to the VR program since it was unlikely that counselors would select older applicants because of the unfavorable labor market for them. He also said that older handicapped individuals who become clients may get less counselor attention because it is more difficult for the counselor to locate jobs for older clients.[117]

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[110] Sawyer Interview; Smith Interview; Jamero Interview; and Botten Interview.

[111] Dirk Schuurman, Deputy Regional Director, Office of Rehabilitation Services, testimony, *San Francisco Hearing*, p. 76.

[112] Darbonne-Magrady Interview.

[113] *Report on Rehabilitation Act of 1972*, p. 21.

[114] Darbonne-Magrady Interview.

[115] Ibid.

[116] Kaminsky Testimony, *San Francisco Hearing*, pp. 79–80.

The Deputy Director of the Federal regional office in Dallas stated that the labor market is the largest single factor affecting the participation of older persons in the VR program. Since the labor market is not as open to an older individual, he said, a counselor may think he or she would be taking a bigger risk in opening a case on an older person rather than a younger one—the risk of not being able to place the individual in a job.[118]

Thus, the treatment of older persons, especially older disabled persons, by the labor market influences their ability to receive VR services. When determining whether older persons are eligible for services, VR counselors must consider whether it is likely that an individual will be placed in suitable employment once rehabilitated. The difficulty in locating jobs for the disabled, added to employment problems for persons over 45, causes counselors to determine that it is not feasible that the older handicapped individual could ever be placed in competitive employment.

Benefits and the Government's Return on Investment

Program administrators in several States visited by Commission staff indicated that when decisions are made about providing services to persons of certain ages, the costs of those services are sometimes considered in light of anticipated return on the investment. They did not indicate that the actual cost of providing the services was related to age, but rather that the expected return varied.

The Mississippi *Manual of Policies* contains the statement that:

> The individual, regardless of age, may be accepted for service if his general physical or mental condition is such that he. . .can be expected to remain in employment a sufficient length of time to justify the expenditures for his rehabilitation.[119]

The Federal regional representative for Mississippi said that because program funds are not available to serve all eligible applicants, VR counselors must make choices about whom they will accept for services. She added that age is one of several factors that enters into the decision. As an example, she said that if a counselor had to choose between two potential clients—one 20 years old and the other 45—the counselor would most likely select the 20-year-old who would be "apt to produce a better return;" that is, after rehabilitation, the younger disabled person could be expected to work longer and thus "pay back" more in terms of tax payments and foregone receipt of transfer benefits.[120]

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[117] Deaver Interview.

[118] Vernon Interview.

[119] *Mississippi Manual*, p. II-2-4.

[120] Carrick Interview.

Dirk Schuurman, the Deputy Regional Director for the Office of Rehabilitation Services in San Francisco, testified that he believes that counselors, when considering applicants, take into account the expected length of employment that would result from an investment of rehabilitation services for the individual. He also claimed that limited funds were available so that such choices had to be made. He said that a counselor who knows that funds are limited is likely to select the younger of two applicants, because there would be a higher probability of a much longer future work period, and "the taxpayer gets more for his return on the investment."[121]

A VR supervisor in a Texas district office reported that, in his view, the basis of a counselor's decision during the application review process was whether the provision of services would produce a "tax-saving" in the individual's case.[122] The decision to provide services should be based rather, he believed, on the possible employment benefits for the individual and not necessarily the anticipated "pay-back" to society for the costs of VR services.

The notion of tax-saving or expected "pay-back" is a feature in the relationship between the VR program the disability insurance (DI) and supplemental security income (SSI)programs. The Social Security Administration will pay for the cost of rehabilitation services for DI and SSI recipients if, by the receipt of such services, the individual can be expected to return to productive activity at a savings to SSA as a result of reduced benefits or nonpayment of benefits and, in the case of DI, as a result of future benefit contributions of the rehabilitated worker to the social security trust fund. The Social Security Act provisions related to DI and Federal regulations related to DI and SSI specify that to use Social Security funds to pay for rehabilitation services, the predicted work period would have to be long enough to offset the cost of services and the anticipated cash assistance payments.[123] This policy tends to limit Social Security funding for rehabilitation for older persons because they would have a shorter anticipated period of work after rehabilitation, and consequently their rehabilitation would be less likely to result in any savings.

The *Rehabilitation Services Manual* issued by the Rehabilitation Services Administration explains the screening guidelines used by SSA to determine whether or not to refer the DI or SSI applicant to the State VR agency. These guidelines have "screen-in," "screen-out," and "grey-area screening" criteria. The automatic screen-in criteria include "applicants to age 45," unless one of the items causing an automatic screen-out is present. The "grey-area" screening table is to be used for those cases that do not meet the screen-in or screen-out criteria. Various factors are to be considered, and "excellent," "good," and "guarded" levels are listed for each. One factor is age, and under 36 is defined as excellent, 36 to 50 as good, and over 50 as guarded.[124]

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[121] Schuurman Testimony, *San Francisco Hearing*, p. 76.

[122] Marnan Interview.

[123] 42 U.S.C. §422(a) (1970); 45 C.F.R. §§1361.111, and 1361.124 (1976).

While this determination of anticipated benefits is only part of the SSA reimbursement program and is not a feature of the VR program, the notion of potential "pay-back" or return was identified during the Commission field study as a major concern of VR counselors in carrying out their program. In Texas a VR supervisor stated that existence of the DI determination process with its consideration of "pay-back" may have a "spill-over" effect on eligibility determinations for basic VR services as well.[125]

A program that operates under a funding ceiling may not be able to serve all persons who apply and are eligible for services. In such cases, priorities must be established, such as the statutorily required priority for the severely disabled in the VR program. The belief of VR staff that resources should be focused on those age groups that will provide society with the greatest return for its investment affects who is accepted for services. This reportedly limits services to older disabled applicants who may meet all of the eligibility requirements.

Negative Staff Attitudes

In five of the sites visited by Commission staff, certain attitudes were expressed about older persons by VR staff. Some of these centered on the view that older disabled individuals have less need or desire to work. Other assertions were that staff prefer to work with younger people rather than older ones. An area supervisor for the Mississippi Vocational Rehabilitation Division reported that the attitude of VR employees was that "survival and maintenance was possible for the older disabled whereas there's a greater need for younger people to work."[126]

Two office directors at the Texas Rehabilitation Commission said that they thought the low program participation rates for the older disabled were explained by the fact that many cases of persons 45 or older where closed in the applicant status, since they tended to "drift into woodwork" and other hobby activities.[127] A VR counselor in Texas said that one factor influencing provision of services to older persons was that staff were less interested in working with the elderly. He said that counselors felt that "older people have had their chance." He added that counselors sometimes derived greater satisfaction from their work by focusing on cases where they felt they could see more productivity, that is, "putting someone in a job for 25 or 30 years as opposed to 5 to 10."[128]

In Washington State, a district administrator and three of his staff indicated that they did not even try to establish a career for older disabled individuals.[129]

As an explanation for the low number of referrals for older disabled persons, a disability determinations district supervisor in Missouri said that "at age 45 the ability [of a person] to adapt reduces." When asked to explain his statement, he

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[124] U.S., Department of Health, Education, and Welfare, Rehabilitation Services Administration, *Rehabilitation Services Manual*, sections 3513 and 3713.

[125] Garza Interview.

[126] Sawyer Interview.

[127] Fenoglio-Jackson Interview.

[128] Marnan Interview.

[129] Botten Interview.

replied, "You can't teach old dogs new tricks."[130]

In Maine, VR counselors claimed that "throughout the VR system" elderly clients are often referred to as the "4-H's—hernias, hemorrhoids, hysterectomies, and hearing aids which add up to homemakers."[131] The director of the State regional office also reported use of the term "4-H's."[132]

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[130] John J. Sapienza, district supervisor, Disability Determinations Division, Missouri Department of Education, interview in Brentwood, Mo., Apr. 5, 1977.

[131] Rowe Interview.

[132] Brady Interview.

Chapter 8

Medical Assistance Program (Medicaid)

The Medical Assistance program was authorized in 1965 by Title XIX of the Social Security Act, as amended,[1] and is usually referred to as Medicaid. The program reimburses States for part of the cost of purchasing medical care on behalf of eligible low-income families and individuals.[2]

> Review of the program identified discriminatory practices on the basis of age in several areas. In one State the practice of requiring prior authorizations for some medical services was found to take age into account in judging an individual's potential employability. No State studied had formal outreach activities except as required for the early and periodic screening, diagnosis, and treatment (EPSDT) services; they relied on referral sources to inform persons of their potential eligibility for Medicaid. It was claimed that some sources did not provide referrals on behalf of all eligible persons, and the Social Security district offices were cited as such a source that primarily affected receipt of services by older persons.

Review of the Medicaid program raised several other issues: notification of parents of services delivered to children and reimbursed through Medicaid, EPSDT participation and outreach activities, eligibility criteria and groups covered by State Medicaid programs, and the range of medical services that states provide on an optional basis.

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[1] Grants to States for Medical Assistance Programs, Pub. L. No. 89-97, 79 Stat. 343 [codified at 42 U.S.C. §§1396-1396j (1970, Supp. V 1975 and U.S.C.A. Supp. 1977)].

[2] 42 U.S.C. §1396b(a) (1970)

Program Description

The purpose of the Medicaid program is to enable each participating State to furnish (1) medical assistance for families with dependent children and for aged, blind, and disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help families and individuals attain or retain the capability for independence or self-care.[3]

Each participating State may design its own Medicaid program within established limitations. A State must submit a plan to the Secretary of Health, Education, and Welfare[4] that describes its specific program, including the groups of persons who will be eligible for participation, the package of medical services to be made available, and the system of service delivery that the State will use.[5] Amendments to the plan must be submitted whenever the State program changes as a result of Federal law or regulation or State action.[6]

The law specifies basic requirements for the State Medicaid plan.[7] The plan must provide for designation of a single State agency to administer the program, except for determination of an individual's eligibility which may be done by a different agency.[8] The State must specify that individuals who are recipients of federally-subsidized, cash assistance programs (aid to families with dependent children and supplemental security income) are eligible for Medicaid and that certain services will be provided to them.[9] A State may, however, place certain limits on these mandatory eligibility groups and services.[10] Additional eligibility groups and services are specified in the law and Federal regulations, and a State may, at its option, include all, some, or none of these in its program.[11] Furthermore, a State must establish standards for institutions that will provide services to recipients[12] and present in the plan the kind and number of health providers that will receive reimbursement through Medicaid payments.[13]

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[3] 42 U.S.C. §1396 (1970).

[4] 42 U.S.C. §1396 (1970).

[5] 42 U.S.C. §1396a (1970 and Supp. V 1975).

[6] 45 C.F.R. §205.5 (1976).

[7] 42 U.S.C. §1396a (1970 and Supp. V 1975).

[8] 42 U.S.C. §1396a(a)(5) (Supp. V 1975). The determination of an individual's eligibility may be made by the State or local agency which administers the aid to families with dependent children (AFDC) program [42 U.S.C. §§601–622 (1970)] or by the Social Security district offices which administer the supplemental security income (SSI) program [42 U.S.C. §§1381–1383 (Supp. V 1975).]

[9] 42 U.S.C. §§1396a(a)(10)(A) (Supp. V 1975), 1396a(a)(13)(B)(1970). The Social Security Amendments of 1975 enacted the supplemental security income (SSI) program but did not make the program applicable to Puerto Rico, Guam, and the Virgin Islands. These jurisdictions still administer the assistance programs that were replaced by SSI. Pub. L. 92–603, title III, §§303(a), (b), Oct. 30, 1972, 86 Stat. 1484 [codified at 42 U.S.C. §§301, 1201, 1351, 1381 (Supp. V 1975).] This chapter discusses the Medicaid program as administered in the U.S., except for Puerto Rico, Guam, and the Virgin Islands.

[10] 42 U.S.C. §§1396a(f)(Supp. V 1975), 1396a(a)(10) (1970 and Supp. V 1975); and 45 C.F.R. §249.10(a)(5)(i) (1976).

[11] 42 U.S.C. §§1396a(a)(10)(C) (Supp. V 1975), 1396d(a) (1970 and Supp. V 1975); and 45 C.F.R. §§, 248.1(c) (d) (1976) pertain to optional eligibility groups. 42 U.S.C. §1396d(a)(6)–(17) (1970 and Supp. V 1975) lists optional services.

Following approval of the plan, Federal money is made available to reimburse a State for part of the cost of services included in the plan.[14] The Federal share of the costs varies inversely with each State's per capita income—the lower the State's per capita income, the higher the Federal share.[15] The current Federal share ranges from 50 percent to 78 percent.[16] No Federal ceiling is placed on the appropriations for Medicaid, which means that a State may be reimbursed with Federal funds for all costs incurred for medical services included in the State's plan up to the limits of the established Federal share.[17]

Groups eligible for Medicaid are classified as either "categorically needy" or "medically needy." The term "categorically needy" is used in the Federal regulations to define those groups of individuals who are eligible because they meet the requirements for one of the categories for cash assistance or meet the exceptions to those requirements allowed under Medicaid.[18] The State must include some groups of the categorically needy, while it may cover others at its option.[19] Individuals who are eligible for the State's aid to families with dependent children (AFDC) program or meet the allowed exceptions must be covered as categorically needy.[20] The categorically needy also include aged, blind, and disabled recipients of supplemental security income (SSI) or State supplements to SSI. A State may limit Medicaid coverage of SSI recipients by using the more restrictive eligibility criteria that were in effect before implementation of SSI.[21] A State must maintain Medicaid coverage for some persons who were eligible under the previous categorical assistance programs but not under SSI.[22]

A State may elect to include "medically needy" individuals in its Medicaid program. To be "medically needy" a person must meet the requirements for receipt of AFDC or SSI, except for the income and resources requirements. If an individual's medical expenses when deducted from his or her income reduce spendable income to a level that would qualify the individual for AFDC or SSI, the person is eligible for

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[12] 42 U.S.C. §1396a(a)(9) (1970).

[13] 42 U.S.C. §1396a(a)(22) (1970). Examples of health providers include a hospital, nursing home, pharmacy, private physician, clinic, dentist, or other practitioner.

[14] 42 U.S.C. §1396b(a) (1970).

[15] 42 U.S.C. §1301(a)(8)(B) (1970).

[16] U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, Medical Services Administration, "Medicaid Services State by State," June 1976, (SRS)-76-24801.

[17] 42 U.S.C. §1396 (1970).

[18] 45 C.F.R. §248.1 (1976). Persons are eligible for Medicaid because they have a characteristic that defines one of the categories of persons covered by public assistance programs—aged, blind, disabled, or dependent children. See 42 U.S.C. §1396d(a) (1970 and Supp. V 1975).

[19] 42 U.S.C. §1396d(a) (1970 and Supp. V 1975) and 45 C.F.R. §248.1 (1976).

[20] 42 U.S.C. §1396a(10)(A) (Supp. V 1975) and 45 C.F.R. §248.1(b) (1976).

[21] 42 U.S.C. §§1396a(a)(10)(A), 1396a(f) (Supp. V 1975); and 45 C.F.R. §248.1(b) (1976).

[22] 42 U.S.C. §§1396a(f), 1382c(a)(2), 1382c(a)(3)(A) (Supp. V 1975); and 45 C.F.R. §248.1(b) (1976).

Medicaid as a "medically needy" individual.[23]

The law provides for Federal reimbursement of the following services, if they are included in the approved State plan:

1. Inpatient hospital services (other than services in an institution for tuberculosis or mental disease).

2. Outpatient hospital services.

3. Other laboratory and X-ray services.

4.(a) Skilled nursing facility services for individuals 21 years of age or older; (b) Early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects and such health care treatment and other measures to correct or ameliorate defects and chronic conditions; (c) Family planning services and supplies.

5. Physicians' services.

6. Medical care recognized under State law.

7. Home health care services.

8. Private duty nursing services.

9. Clinic services.

10. Dental care.

11. Physical therapy and related services.

12. Prescribed drugs, dentures, and prosthetic devices and eyeglasses.

13. Other diagnostic, screening, preventive, and rehabilitative services.

14. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 or over in an institution for tuberculosis or mental disease.

15. Intermediate care facility services (other than in an institution for tuberculosis or mental disease) for individuals who are determined to be in need by a professional review process.

16. Inpatient psychiatric hospital services for individuals under 21.

17. Any other medical care and type of remedial care recognized by State law.[24]

The law requires that a participating State provide only the first five services listed above to the mandatory eligibility groups, and home health care for those individuals eligible for skilled nursing facility services.[25]

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[23] 42 U.S.C. §§1396a(a)(10)(C), 1396d(a) (Supp. V 1975), and 45 C.F.R. §248.1(a)(2), 248.1(d) (1976). Federal regulations specify that the income limit for the medically needy may be no higher than 133 1/3 percent of the State's AFDC payment for the same size household. 45 C.F.R. §248.4(b)(4)(i) (1976).

[24] 42 U.S.C. §1396d(a)(1)-(17) (1970 and Supp. V 1975). The service designated as item 4 is actually three different services listed as subitems. The list of services are numbered in this manner in the statute. Since the "first five services" are referenced frequently and include all three services in item 4, the method of numbering has been maintained in this report.

Medicaid eligibles may obtain services from any health provider certified by the State to perform certain services. The health provider then bills the State Medicaid agency directly for services provided. Payments for any services furnished that are included in the State plan are then made directly by the State to the health provider.[26]

The law requires a State to ensure the provision of early and periodic screening, diagnosis, and treatment (EPSDT) services to eligible persons in families receiving AFDC either by arranging for their provision or by providing them directly.[27] Federal regulations expand this requirement to all persons eligible for EPSDT under a State's Medicaid plan; that is, medically needy and SSI eligibles as well as AFDC eligibles.[28] This requirement is broader than that for all other Medicaid services except for family planning services.[29] For all other services the State is not required to ensure that services are provided, but is required merely to pay for them. The law also requires a State to inform all AFDC families of the availability of EPSDT services and imposes a financial penalty for failure to comply through the Federal reimbursement of AFDC costs.[30]

Federal regulations define specific activities that a State must carry out in providing EPSDT services:

- Inform all AFDC families at least once a year in writing that screening services are available.

- Provide or arrange for screening services for recipients within 60 days of the time that the family requests such services and assist the recipient in obtaining them, including making transportation services available.

- Pay for and make available diagnostic services to those found in need of diagnosis during the screening process.[31]

- Make available and pay for the treatment of conditions discovered during screening and diagnosis within the limits of the State's Medicaid plan. In addition, a State must make "eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health. . .available. . .whether or not otherwise included under the State plan."[32]

The Health Care Financing Administration of the Department of Health, Education, and Welfare administers the Medicaid program at the Federal level.[33]

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[25] 42 U.S.C. §1396a(a)(13)(A)(ii); and (B) (1970).

[26] 42 U.S.C. §1396a(a)(32)(1970).

[27] 42 U.S.C. §603(g)(2) (Supp. V 1975).

[28] 45 C.F.R. §249.10(a)(3)(i)(1976).

[29] 42 U.S.C. §1396d(a) (Supp. V 1975). The statute requires that a State furnish family planning services and supplies directly or under arrangements with others.

[30] 42 U.S.C. §603(g) (Supp. V 1975).

[31] 45 C.F.R. §205.146(c) (1976).

[32] 45 C.F.R. §249.10(a)(3)(iv) (1976).

[33] The reorganization of several health-related

Summary of the Record

Program Participants

Although extensive data are collected concerning the Medicaid program and the general population's health status, data necessary for the analysis of program benefits on the basis of age are unavailable. The Department of Health, Education, and Welfare reports monthly, quarterly, and annual data on Medicaid beneficiaries and types of services provided by total recipients or eligibility categories. In some cases the data are analyzed by age in annual reports, the most recent for fiscal year 1974.[34] This information largely conforms to age categories corresponding to the eligibility groups—under 6 years, 6 to 20, 21 to 64, and 65 or over.[35] Since the receipt of Medicaid benefits is based on incurring a medical expense in addition to meeting other eligibility criteria, program data are reported for recipients—persons who actually receive services.[36] Information on those who are determined eligible for Medicaid but do not require services are not reported. Thus, the data on recipients may not necessarily reflect the age distribution of the population covered by Medicaid. Determining the population eligible for Medicaid services is difficult because of the varying eligibility groups and age restrictions for certain services imposed by different States. Each State's eligible population would have to be determined separately.[37] The lack of data on health needs by different age groups hampers comparison of recipients with the distribution of the population in need of

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agencies into the Health Care Financing Administration was announced by the Department of Health, Education, and Welfare in "HEW News" dated Mar. 8, 1977. Before that time, the Medicaid program was administered at the Federal level by the Medical Services Administration within the Social and Rehabilitation Service. At the time of the Commission's field study, the reorganization of the Department of Health, Education, and Welfare regional office staffs had not been completed to follow the formation of the Health Care Financing Administration in Washington, D.C. The Federal regional offices were operating under the previous organizational structure.

[34] While monthly reports were available for 1977, the most recent program data for age groups were for fiscal year 1974. The data were contained in two reports: U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Number of Recipients and Amounts of Payments under Medicaid, Fiscal Year 1974*, NCSS Report B-4 (FY 74), 1976 (hereafter cited as *Recipients and Payments*); and U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medicaid Recipient Characteristics and Units of Selected Medical Services, Fiscal Year 1974*, NCSS Report B-4 (FY 74) Supplement, 1977 (hereafter cited as *Medicaid Recipient Characteristics*).

[35] The only age group which is categorized more discretely than when the data are reported by eligibility categories is that "under 21." The eligibility groups are dependent children and other Medicaid recipients under 21. (This latter group is a relatively minor part of all child Medicaid beneficiaries, 3.8 percent compared to 96.2 percent who are dependent children. See *Recipients and Payments*, pp. 15–16.) Age data on children are divided into the categories of under 6 and 6 to 20.

[36] The term "recipients" as used in the reported data means "persons for whom vendor payments were made for one or more types of care during the year." *Recipients and Payments*, p. 12.

[37] In 1975, the Urban Institute estimated the population eligible for Medicaid using a computer microsimulation of the U.S. population and applying the Medicaid eligibility criteria against it. The work was performed for the Federal Council on the Aging for their study entitled *The Interrelationships of Benefit Programs for the Elderly*. Estimates were made for the different eligibility groups, but there were several problems with the procedure. The eligibility criteria applied to the population data did not account for all of the differing States' eligibility rules. Also, the data were for a calendar year thereby overlapping with program data for two fiscal years.

services offered by the program. Data on health status are reported primarily on diagnosed problems, services given, or expenditures by type of service. In addition, the comparison of data on Medicaid recipients and eligibles is restricted because varying age groups and categories of services are used in the different data bases. What data are available, however, are reported below.

In fiscal year 1974, approximately 22 million persons received medical services for which the Federal and State governments made Medicaid payments totaling $10 billion.[38] The distribution of those Medicaid recipients by age is shown in table 8.1.

The distribution of total Medicaid payments for the reported age groups, shown in chart 8.1, differs from the age distribution of recipients. While children under 21 make up a large segment (47.9 percent) of the recipients, payments for services to that age group account for only 18.4 percent of the total. Persons aged 65 or older constitute the smallest group (17.5 percent) of beneficiaries, and yet a very large proportion of the payments (39.1 percent) are made in their behalf.[39]

The primary explanation for the variations in the proportion of recipients in an age group and the distribution of funds to that group is the cost of the different services that are provided to different age groups. An examination of the service provision rates for different age categories of recipients shows that the rates vary by service.[40] (See table 8.2.)

The rates also show that some age groups use certain services at either higher or lower rates than other groups. Generally, recipients who are 65 or older have higher rates for institutional services, which tend to be more expensive than other medical services provided under Medicaid.[41] Children under 21 have a lower rate for general hospital services than the average for all recipients, while adults 21 to 64 and, especially, those 65 or older have rates higher than the average. Persons aged 65 or older are provided skilled nursing home care at a rate higher than that for all recipients. Children under 21 have very low rates for this service. The pattern shown for skilled nursing homes is also reflected in the rates for intermediate care facilities, other than for the mentally retarded. Persons 65 or over are provided dental services, outpatient hospital services, and clinic services at a rate well below that of the other age groups.

The Social Security Administration's (SSA), Office of Research and Statistics issues estimates of health care expenditures, including estimates by age. (See table 8.3) Even though SSA's age classifications are slightly different from those used to report Medicaid program data,[42] rough comparisions can be made between the two sets of data. (See chart 8.1 for the distribution of Medicaid expenditures by age). Adults under 65 (defined as age 19 to 64 by SSA and age 21 to 64 by Medicaid) account for the largest proportion of both health and Medicaid expenditures. The second largest proportion of both health and Medicaid expenditures is for persons 65 or over. According to both sets of data, the youngest age group (those under 19 in SSA data and under 21 in Medicaid data) accounts for the lowest expenditures—16.1 percent of all health expenditures are for those under 19 and 18.4 percent of Medicaid expenditures are for those under 21.[43]

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[38] *Recipients and Payments*, p. 1.

[39] *Medicaid Recipient Characteristics*, p. 3 and table 4.

[40] Ibid., tables 1, and 5–8.

[41] Marjorie Smith Mueller and Robert M. Gibson, "Age Differences in Health Care Spending, Fiscal Year 1975," reprinted from the *Social Security Bulletin*, June 1976, p. 2.

Practice of Requiring Prior Approvals

In a 1977 study of cost controls in the State Medicaid programs, the Urban Institute reported that over half of the States require prior authorization or approval for receipt of Medicaid services.[44] A State employing this procedure requires that physicians and other health providers obtain approval before providing certain medical services if they are to be reimbursed under Medicaid. The types and number of services for which prior approval is required vary by State but usually include nonemergency services.

States use a system of prior approvals to control costs, and also, they claim, to ensure that only medically necessary services are provided.[45] This dual purpose has been recognized since as early as 1970, when staff of the Senate Committee on Finance recommended that States "curb overutilization through prior approval of certain services."[46] The staff reported:

> States should adopt procedures for prior independent professional approval of elective surgery, dental care (except for minor procedures), eye care, and hearing aids.
>
> The experiences of several States indicate that a system of prior approval for selected types of costly health care can be an effective method for controlling utilization and costs as well as avoiding the exposure of recipients to unnecessary hazard and pain.[47]

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[42] The age groups used by the Social Security Administration to report health expenditures are under 19, 19 to 64 and 65 or over. The groups used for Medicaid data are under 6, 6 to 20, 21 to 64 and 65 or over.

[43] The pattern is the same for both health and Medicaid expenditures by age, but the proportions are different. For all health expenditures 16.1 percent are for those under 19, 57.4 percent are for those 19 to 64 and 26.5 percent are for persons 65 or over. Medicaid expenditures are divided 18.5 percent for persons under 21, 41.5 percent for those 21 to 64 and 39.1 percent for those 65 or over. The major differences occur with the two "adult" groups. Perhaps these differences are due to Medicaid eligibility criteria which exclude persons between 21 and 64 unless they are blind, disabled, or the caretaker of a dependent child and the age limitations which are placed on specific services by the statute and in State plans.

[44] John Holahan and Bruce Stuart, *Controlling Medicaid Utilization Patterns* (Washington, D.C.: The Urban Institute, 1977), p. 68

[45] Ibid., pp. 53–54.

[46] U.S., Congress, Senate, Committee on Finance, *Medicare and Medicaid: Problems, Issues and Alternatives*, 91st Cong., 1st Sess., 1970, Comm. Print, p. 128 (hereafter cited as *Medicare and Medicaid*).

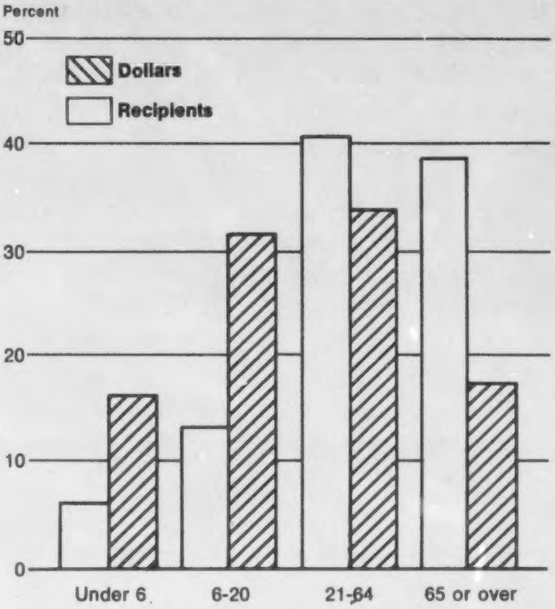
[47] Ibid.

The use of prior authorization may or may not be effective to control unnecessary services or program costs.[48] All nine States covered by the field study and public hearings use prior authorizations for at least some services.[49] In several cases the purpose of the practice was stated to be "screening for medical necessity." Officials also stated that such determinations would not affect any age groups adversely.[50] However, it appears that in some States, prior authorization was refused if persons were considered "too old" for a procedure to be cost effective.

Reports from the State of Washington indicated that age of the recipient is

Chart 8.1

Distribution of Medicaid Recipients and Payments by Age, Fiscal Year 1974 *



* Excludes those whose age is unknown.

Source: U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *Medicaid Recipient Characteristics and Units of Selected Medical Services, Fiscal Year 1974*, NCSS Report B-4 (FY 74), Supplement, 1977, p. 3.

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[48] Holahan and Stuart, *Controlling Medicaid Utilization Patterns*, pp. 53–54.

[49] Thomas Singleton, chief, Missouri Bureau of Medical Services, interview in Jefferson City, Mo., Apr. 11, 1977 (hereafter cited as Singleton Interview); John Fickett, director, Maine Division of Medical Assistance, interview in Augusta, Me. (hereafter cited as Fickett Interview); Vivian Sossin, Illinois regional administrator, with John Omori, interview in Chicago, Ill., May 17, 1977 (hereafter cited as Sossin Interview); *Washington Medicaid Plan* August 25, 1976; *Texas Medicaid Plan; Mississippi Medicaid Plan;* Doris Soderberg, chief, Medical Division, California Department of Health, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27–28, 1977, vol. I, p. 117 (hereafter cited as *San Francisco Hearing*); Dr. Gary Toerber, director, Colorado Division of Medical Assistance, testimony, *Hearing Before the U.S. Commission on Civil Rights, Denver, Colorado,* July 28–29, 1977, vol. I, pp. 67–68 (hereafter cited as *Denver Hearing*); and James Morrison, Florida Medicaid administrator, testimony, *Hearing Before the U.S. Commission on Civil Rights, Miami, Florida,* August 22–23, 1977, vol. I, p. 45 (hereafter cited as *Miami Hearing*).

[50] Singleton Interview; Soderberg Testimony, *San Francisco Hearing*, p. 117.

considered during the prior approval process. It was reported that potential employability of the Medicaid recipient is a key factor in obtaining prior approval, especially in the case of nonemergency surgery. It was further claimed that although older persons have a proportionately greater need for surgery, they can rarely demonstrate that recommended surgery will lead to employment, so approval is not granted.[51]

The director of the Evergreen Legal Services program in Seattle reported that his program had instituted a class action suit on behalf of Medicaid recipients who had been denied reimbursement because "funds were not available." In one particular case, Medicaid reimbursement for a hip operation had been denied allegedly on the grounds that the individual was too old and that Pay-back" to the State through future employment could not be expected. The recipient was 45 years old.[52]

The chief of the Washington State Office of Medical Assistance and two of his staff reported that age is a factor when reviewing requests for prior approval of services because of limited funds. They claimed that "all other things being equal," children take priority over adults or older persons for services because the treatment of the young is considered the most cost effective. They stated as an example that officials reviewing prior approval requests would never approve reimbursement for a hernia repair for an older person in a nursing home, while they might approve such a request for a younger person who might then be able to be employed.[53]

The Federal regional representative for Medicaid claimed that the State's greater inclination to approve reimbursement for services for the young is a fact well known by the State's physicians and has the effect of deterring them from requesting prior approval for some services for older persons. He stated that this is common practice in respect to most services that might improve a person's condition but are not essential for survival. Although no documentation existed on the number of deferred or denied requests, he considered the problem to be "quite extensive and severe."[54]

Such use of age or age-related criteria should not be included in the prior approval process, according to Robert Derzon,

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[51] Richard Nelson, chief, Washington State Office of Medical Assistance and staff, interview in Olympia, Wash., May 3, 1977 (hereafter cited as Nelson Interview); David Haffie, regional program representative, interview in Seattle, Wash., May 4, 1977 (hereafter cited as Haffie Interview); and Gregory Dallaire, director, Evergreen Legal Services Program, interview in Seattle, Wash., May 4, 1977 (hereafter cited as Dallaire Interview).

[52] Dallaire Interview. Since the time of the field study, Commission staff has learned that the case has been resolved by the issuance of a consent order in which the State has agreed to review prior approval requests only on the basis of medical necessity. Availability of funds may not be a factor in such decisions. According to the attorney who represented the plaintiffs, State officials indicated that age and potential employment possibilities of the Medicaid recipient were factors considered during the prior approval process. These statements were made in depositions and responses to interrogatories. They were not part of the public record because both parties agreed to the consent order before a trial. Jeff Spence, attorney, Evergreen Legal Services, telephone interview in Seattle, Wash., Apr. 26, 1978.

[53] Nelson Interview.

[54] Haffie Interview.

Administrator of the Health Care Financing Administration (HCFA) of the Department of Health, Education, and Welfare. He testified that age or potential employability may not be used in order to determine medical necessity.[55]

Outreach and Referral Activities

None of the six States in the field study had a formal outreach program to inform eligible persons of the Medicaid program, its services, and its procedures, except for the early and periodic screening, diagnosis, and treatment (EPSDT) service component of the program. Referrals from other agencies were the most frequently cited means of informing people of the program. Medicaid officials tend to rely on those referral sources rather than conduct their own outreach. Several States reported problems with the referral process as executed by the Social Security district offices, which have contact with many persons eligible for Medicaid through administration of the SSI program.

Neither the statute nor the Federal regulations require that a State provide or sponsor outreach activities for its Medicaid program except for EPSDT services, and States in the field study indicated that they usually have not instituted formal outreach activities.[56]

Since Medicaid eligibility overlaps with eligibility for federally-funded cash assistance programs, referrals of persons determined eligible for cash assistance is the most widely used procedure for the identification and intake of Medicaid recipients. In addition, community centers, private voluntary organizations, and health providers are frequent referral sources.[57] Robert Derzon, Administrator of HCFA, explained:

> [M]uch of the stimulus for Medicaid eligibility comes about in hospitals and other provider service areas by the providers themselves because as a method of reimbursement Medicaid is still a better program than no reimbursement at all. So you have, for example, in most public hospitals eligibility workers and others who actually stimulate Medicaid participation.[58]

Another method of providing information to the eligible population is to distribute materials about the program. The Department of Health, Education, and Welfare prepares materials about the Medicaid program and distributes them to the States. The States or local agencies in turn make them available in places frequented by the eligible population. Mr. Derzon testified, however, that "States vary in their determination to make that information available."[59]

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[55] Robert A. Derzon, testimony, *Hearing Before the U.S. Commission on Civil Rights, Washington, D.C.*, Sept. 26–28, 1977, vol. I, p. 89 (hereafter cited as *Washington, D.C. Hearing).*

[56] Shirley Rankin, associate county director for eligibility determination, interview in Jackson, Miss., Apr. 27, 1977 (hereafter cited as Rankin Interview); Nelson Interview; Singleton Interview; Fickett Interview; and Morrison Testimony, *Miami Hearing*, pp. 47–48.

[57] Anne Dintelmann, Medicaid social worker, interview in St. Louis, Mo., Apr. 4, 1977 (hereafter cited as Dintelmann Interview); Rankin Interview; Fickett Interview; and Morrison Testimony, *Miami Hearing*, p. 48.

[58] Derzon Testimony, *Washington, D.C. Hearing*, p. 83.

Various reasons were offered for not conducting active outreach for the Medicaid program. The most frequent was that resources are not available to finance such activities, including both funds and staff time.[60]

It was claimed that the increasing costs of the Medicaid program are placing greater burdens on the States' budgets and that States are searching for methods to control these costs, not add to them.[61] Many States view an outreach program as increasing costs and so do not implement such activities, according to James Morrison, Medicaid administrator of the Florida Department of Health and Rehabilitative Services. He explained:

> I think there is, in most States, opposition—immediate opposition—to the idea of outreach, in other than the social [service] agency. The fiscal, budget people immediately react against it. They see an increase in caseloads. The opposition is usually at that level.[62]

Mr. Morrison agreed that there is a deliberate effort on the part of certain officials to hold down outreach in order to hold down cost and that effort is at the expense of the welfare of the older persons.[63]

Robert Derzon also said that money constraints are a factor in a State's decision not to perform outreach.

> I think it is a fair statement to say that most States at this point in time do not go out and strongly advertise the Medicaid program, because each extra Medicaid expenditure represents another dollar of State financing.[64]

The chief of the Missouri Bureau of Medical Services reported that his agency conducted no formal outreach because "no advertising of the program [was] needed." He based this on the fact that 10 percent of the State's total population had been served during 1976. He also claimed that there was an upper limit on the Medicaid funds available, so that at least full reimbursement for services could not be provided after the limit was reached.[65] Since there is no Federal ceiling on Medicaid funds, this "upper limit" constraint refers to limits on State appropriations.

Because of the interrelated eligibility requirements for Medicaid and the Federal cash assistance programs, referrals from the agencies administering the assistance programs are a major source for locating persons eligible for Medicaid. In most States, eligibility for the Medicaid program is determined by the same agency that administers the AFDC program, which serves primarily children,[66] and "administrative coordination between the two programs is not a major issue."[67] Before enactment of the SSI program, cash assistance programs for adults were usually administered by that same agency. SSI, which serves primarily adults,[68] is administered by the Social Security Administration and eligibility is determined by their district offices. A recent report of the Department of Health, Education, and Welfare on Medicaid eligibility indicates that separating responsibility for cash assistance for the aged, blind, and disabled from the State public welfare agencies has adversely affected recipt of Medicaid by recipients of SSI:

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[59] Ibid., pp. 82–83.

[60] Rankin Interview; and Doris Norbraten, county medical services coordinator, testimony, *Miami Hearing*, p. 47.

[61] U.S., General Accounting Office, *History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966–1975* (Washington, D.C., 1976) pp. 11–15; and John Holahan, William Scalon and Bruce Spitz, *Restructuring Federal Medicaid: Controls and Incentives* (Washington, D.C.: The Urban Institute, 1977) pp. 1–22 (hereafter cited as *Restructuring Federal Medicaid*).

[62] Morrison Testimony, *Miami Hearing*, p. 48.

[63] Ibid.

[64] Derzon Testimony, *Washington, D.C. Hearing*, p. 83.

[65] Singleton Interview.

> . . .This division of responsibility has caused tremendous problems for Medicaid program administration. Since Medicaid eligibility overlaps with eligibility for cash assistance, it is critical that the two programs operate in a coordinated fashion. However, since the beginning of SSI, coordination has been a major problem. There are inconsistencies in policy between the two programs which have led to conflicting eligibility determinations by the two agencies. There is also a serious lack of administrative coordination between the two agencies, which has added immeasurably to the administrative problems of the Medicaid program. *Given that one of the major purposes of the SSI program was to simplify programs of assistance for the aged, blind, and disabled, there is considerable irony in the fact that SSI has made administering Medicaid eligibility for those groups far more complicated than it was prior to conversion.* [69]

Both the referral process and the information provided by the Social Security district offices were reported to be problems in two of the six States in the field study and in one State where a public hearing was held. The problems affected both those who were eligible for SSI and State supplements and those who were ineligible for SSI but might have been eligible for Medicaid.[70]

The Social Security Act specifies three options for determining eligibility of SSI recipients for Medicaid: (1) the Social Security district office determines Medicaid eligibility by determining SSI eligibility; (2) the State determines Medicaid eligibility using SSI criteria; or (3) the State determines Medicaid eligibility using the more restrictive assistance eligibility criteria in effect before SSI.[71] In the first option, SSI client information is transferred to the Medicaid agency by computer records, and the agency supplies the eligible individual with a Medicaid card and information (usually by mail) with no personal contact being necessary. If the State Medicaid program covers other groups of categorically needy or medically needy, a person who is ineligible for SSI must contact the Medicaid agency directly to apply. Under the latter two options the SSI recipient always must contact the Medicaid agency to make a separate application.

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[66] The program also services adults who are caretakers of eligible children. 42 U.S.C. §606(c) (1970).

[67] U.S., Department of Health, Education, and Welfare, Health Care Financing Administration, *Comprehensive Review of Medicaid Eligibility,* prepared by Urban Systems Research and Engineering, Inc. (1977), p. 4–59 (hereafter cited as *Comprehensive Review of Medicaid Eligibility*).

[68] 42 U.S.C. §§1382c(a)(2), (3)(A) (Supp. V 1975). Persons under 18 who are blind or disabled and meet the other eligibility criteria are covered by SSI.

[69] *Comprehensive Review of Medicaid Eligibility,* pp. 4–39—4–40.

[70] Loren Lange, regional program specialist for assistance payments and Medicaid eligibility, interview in Kansas City, Mo., Apr. 12, 1977 (hereafter cited as Lange Interview); Richard McConnell, regional program supervisor, interview in Seattle, Wash., May 5, 1977; and Norbraten Testimony, *Miami Hearing,* p. 45.

A Federal Medicaid eligibility and assistance payments program specialist in Kansas City reported that the referral process was a problem in States where Social Security district offices determine Medicaid eligibility by determining eligibility for SSI. While there were some cases where SSI eligibles were not told of their Medicaid eligibility, he said that this was not frequently the case. The more serious problem was with persons who were ineligible for SSI because their resources or income were above the acceptable SSI limits but who were not informed of their possible Medicaid eligibility. This occurs, he said, because the "Social Security staff do not know the Medicaid rules and regulations" and specific eligibility criteria. The Social Security district offices do not inform the Medicaid agency of those who apply for SSI but are ineligible.[72]

Missouri uses Medicaid eligibility criteria for the aged, blind, and disabled that are more restrictive than those for SSI so the State agency must take all applications. The director of the income maintance unit of Missouri's Department of Social Services reported that Social Security district offices do not always refer persons to the Medicaid agency. Since the Medicaid agency did not conduct outreach but relied on referral sources to inform possible eligibles of the program, lack of coordination between his agency and the Social Security district offices limited the possibilities of an effective referral process. The director reported that his office determined eligibility for State-administered cash assistance, Medicaid, food stamps, and Title XX social services, but they have had difficulties with the Social Security district offices and their referrals since SSI began. He said that the State agency "doesn't do anything with the Social Security Administration" to attempt to improve the "difficulties."[73]

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[71] 42 U.S.C. §1383c (Supp. V 1975). Section 1634 of the Social Security Act authorizes Federal determination of Medicaid eligibility through the SSI determination process, and a State which elects this option is called a "1634 State." A State which uses SSI eligibility criteria to determine Medicaid eligibility but makes a separate determination is called a "Title XVI State" which refers to the title authorizing SSI. 42 U.S.C. §§1381-1383 (Supp. V 1975). Section 209(b) of the Social Security Amendments of 1972 authorizes the use of more restrictive eligibility criteria used by a State for cash assistance programs prior to the implementation of SSI, and a State choosing this option is referred to as a 209(b) State. 42 U.S.C. §§1396a(f) (Supp. V 1975).

[72] Lange Interview.

[73] Lloyd Conley, director, Income Maintenance Unit, Missouri Department of Social Services, interview in St. Louis, Mo., Apr. 22, 1977.

Adults, who represent the majority of all SSI recipients, are adversely affected by a lack of Medicaid outreach activities whenever there are problems with the interagency referral system. The same agency that determines eligibility for AFDC usually determines Medicaid eligibility, and since a person eligible for AFDC is automatically eligible for Medicaid, the determination is usually made at the same time; however, the system for eligibility determination does not always work so easily for SSI applicants. Problems range from inadequate provision of information to SSI recipients to claims that the Social Security workers do not refer SSI applicants who might be eligible for Medicaid even though they are ineligible for SSI. The lack of outreach and good working relationships with the Social Security district offices affect access to the Medicaid program to a greater extent for SSI applicants or recipients than for other categories of eligibles. SSI recipients are primarily adult and the majority (55 percent) are 65 or over.[74]

Other Issues

Notification of Parents

Services provided under the Medicaid program are not always available to adolescents on a totally confidential basis. Sometimes parents are informed directly when their children request or receive Medicaid-financed services, such as birth control, abortion, and treatment for venereal disease or drug dependency.[75] There is also indirect notification of parents by means of a "fraud check," which is a State administrative procedure that applies to all recipients, not just adolescents. This is an itemized list of services received by all family members that is sent to a family for verification.

Birth control, abortions, treatment for venereal disease, and drug dependency programs are medical services that adolescents may want without involving their parents, and reimbursement through the Medicaid program may be the only financial means available for them to obtain such services.[76] It is alleged that notification of parents deters teenagers from obtaining needed services.[77]

Dr. Roger Wade, director of the Boulder Valley Health Clinic in Denver, testified that teenagers report great difficulty in obtaining funds for birth control and abortions. When a teenager is the member of a family certified for Medicaid, Dr. Wade claimed that the possible notification of the parents

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[74] U.S., Department of Health, Education, and Welfare, Social Security Administration, *Social Security Bulletin*, January 1978, vol. 41, no. 1, table M-22, p. 44.

[75] Dr. Roger Wade, director, Boulder Valley Health Clinic, testimony, *Denver Hearing*, p. 56.

[76] Depending on a State's definitions and scope of services, some or all of the specific services discussed may be available to Medicaid eligibles. The law requires that family planning services and supplies be furnished to eligible individuals "of child-bearing age (including minors who can be considered to be sexually active)." 42 U.S.C. §1396d(a)(4)(C) (Supp. V 1975). Treatment for venereal disease and drug dependency would be required treatment if detected through screening as required by EPSDT.

[77] Wade Testimony, *Denver Hearing*, pp. 55–56; and Children's Defense Fund, *EPSDT: Does It Spell Health Care For Poor Children?* (Washington Research Project, Inc.: Washington, D.C., 1977) p. 133 (hereafter cited as *EPSDT*).

> . . .causes a lot of fear among teenagers, that if they go to obtain birth control, even though it is covered by Medicaid,. . .that this is going to be disclosed to the parents. There's a lot of talk about this among teenagers, and it discourages them from obtaining birth control.[78]

In a study of EPSDT services, the Children's Defense Fund (CDF) reported that the fraud check procedure hampered attempts to serve adolescents. The report stated that fraud checks were a "great deterrent" for adolescents to use Medicaid for needed screening or services. The report quotes one child care worker as saying:

> Adolescents here know that any health service they get from Medicaid is going to show up on a bill which their whole family sees. They don't have the option of being checked for VD or pregnancy without the parents knowing. So, of course, they don't want the service.[79]

Although the process of using fraud check mailings to Medicaid families is not intended to solicit consent for services that have been provided to their children, it often produces that result. Parental consent may not be required for birth control, abortions, treatment of venereal disease and drug dependency programs for adolescents; nevertheless, the notification of parents, even by a process designed for another purpose, is a form of obtaining "implied consent." The adolescent knows the parent will eventually be informed that the service was obtained, and his or her right to obtain the service without parental consent may be, in effect, denied or at least curtailed.

Early and Periodic Screening, Diagnosis, and Treatment

Most reports from the field study and public hearings indicated that EPSDT services were focused on children under 6 and that those 6 to 20 were underserved.[80]

Several problems prevent comparing national EPSDT data to the eligible population. First, program data are reported for the number of screenings provided for only two age groups—less than 6 years and 6 to 20 years. Second, the data are reported by the actual number of screenings performed and not by the number of children screened. Since more than one screening could be provided to a child each year, the actual number of children served cannot be ascertained. As with the total population eligible for Medicaid, variations in State eligibility rules hamper efforts to determine the population eligible for EPSDT. The Health Care Financing Administration reported a total of 146,912 screenings in April 1977—46.2 percent were for children under 6 years and 53.7 percent were for children 6 to 20 years of age.[81]

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[78] Wade Testimony, *Denver Hearing*, p. 56.

[79] *EPSDT*, p. 133.

[80] Sossin Interview; W. John Dye, associate regional commissioner, Medicaid, interview in Chicago, Ill., May 20, 1977 (hereafter cited as Dye Interview).

[81] U.S., Department of Health, Education, and Welfare, Health Care Financing Administration, *Medicaid Data, April 1977*, Medicaid Report B-1 (4/77), tables 16, 15, and 17.

Neither the statute nor the Federal regulations specify the number or frequency of screenings that States must provide under their programs. However, the Medical Services Administration of the Department of Health, Education, and Welfare sponsored the development of a guide on screening by the American Academy of Pediatrics, which recommends 14 screenings over an individual's first 21 years—from 6 screenings during the first 14 months to only 1 for those between 16 to 21.[82] States are not required to follow the guide's recommendations, and, in fact, some States have a policy of one screening a year regardless of age.[83]

In Illinois, local and Federal regional officials agreed that EPSDT services were focused on preschoolers, and they defended this skewing of resources on grounds that younger children stand to derive the most benefit from preventive care.[84] In fact, the Federal Associate Commissioner for Medicaid in Chicago claimed that the under 21 age range for EPSDT services had been arbitrarily selected and the range should have been under 14 years. He said that health needs were the greatest in the first 13 years and that teenagers were an extremely healthy group.[85]

Asked whether EPSDT services are targeted at children under 6, Robert Derzon testified:

> . . .on a number of grounds, EPSDT was really set up so that it could address the problems of the very young, and. . .not, certainly, as frequently, children in the older age groups. That may or may not be sound, but nevertheless, I think that's what the people who direct the program and in fact what most providers who participate in the program do.[86]

One State in the Children's Defense Fund (CDF) study of EPSDT collected data on the number of screenings for age groups smaller than the two categories reported nationally. The CDF report compares the number of screenings performed, the estimated eligible population age distributions, and the State's recommended screening schedules.[87] (The data must be viewed with one qualification concerning the estimates of the eligible population. Children under 21 in families with incomes below $7,500 in 1974 were used as the eligible base, and all such persons may not have been eligible for Medicaid.) According to the Children's Defense Fund's analysis, the data showed "that EPSDT reaches far too few very young children and far too few older adolescents in proportion to the total number of children screened".[88] Their analysis indicated that the youngest and oldest age categories of eligibles are underserved—children under 3 years should have constituted 31 percent of those screened, but made up only 22 percent; and 23 percent of the children screened should have been between 16 and 21 years, but they comprised only 13 percent of those actually served. The data also indicate that the middle group, children 3 to 15 years, are underserved in relation to the total population screened.

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[82] U.S., Department of Health, Education, and Welfare, Social and Rehabilitation Service, *A Guide to Screening for the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) under Medicaid*, prepared by William K Frankenburg and A. Frederick North (Washington, D.C.: Government Printing Office, 1974), p. 54.

[83] *EPSDT*, p. 126.

[84] Sossin Interview; Dye Interview.

[85] Dye Interview.

[86] Derzon Testimony, *Washington, D.C. Hearing*, p. 90.

[87] *EPSDT*, pp. 275–77. The State's recommended screening scheduled allowed for fewer screenings than recommended by the American Academy of Pediatrics so comparisons were made against the State's own schedule.

Furthermore, the Children's Defense Fund demonstrated that if data had been available only for the two age groups of under 6 and 6 to 20 years, they would have indicated only slight differences between the recommended number of screenings for each age group and the actual number of children served. The under-6-year-old group would have been shown to be underserved by 5.4 percent and the 6-to-20 group would have been reported overserved by 3.9 percent. The Children's Defense Fund claimed that reporting data only for the two categories had the effect of hiding "the dramatic disparities in the screening rates for the different age groupings."[89]

As required by law and Federal regulations, all States visited by Commission staff conducted some outreach activities for EPSDT; however, the activities identified were sometimes limited to the minimum requirements and often no attempts were made to rectify low participation rates.[90]

The Health Care Financing Administration recently published a series of training materials for the EPSDT services that recognize the need for aggressive outreach activities in general and specifically for youth.

> Outreach activities are a key to the success of EPSDT. They consist of all efforts to identify, inform, and involve eligible children and youth in EPSDT. While mailing information about EPSDT with welfare checks is a part of outreach, it is seldom enough. A more successful approach involves personal contact between EPSDT workers and potential participants. Phone calls are usually more effective than letters, and personal visits are generally more effective than phone calls. The time and effort EPSDT workers put into outreach and case contact activities can mean the difference between the success and failure of the program.[91]

The materials point out that outreach activities need to be aimed at parents and also at youth, who must be convinced to use the services other than through contacting their parents. EPSDT workers are advised to "make a special effort to reach teenagers" and to "remember that teenagers or young adults may have a different circle of contacts than their parents." The materials further recommend that EPSDT workers use the right contacts and methods for the type of person they are trying to reach.[92]

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[88] *EPSDT*, p. 275.

[89] Ibid., pp. 276–77.

[90] Ibid. pp. 86–94; Nelson Interview, Lange Interview; Harvey Morgan, coordinator of social services planning, Missouri Division of Family Services, interview in Jefferson City, Mo., Apr. 7, 1977 (hereafter cited as Morgan Interview).

[91] U.S., Department of Health, Education, and Welfare, Health Care Financing Administration, *A Brief History of the Medicaid Early and Periodic Screening, Diagnosis and Treatment Program, EPSDT* (1977) p. 11.

The law requires only that an annual written notification of EPSDT services be made to AFDC recipients. Several studies have indicated, however, that more aggressive and personal outreach techniques are necessary to ensure success. In 1975 the General Accounting Office released a report concerning EPSDT implementation which noted that States using more aggressive outreach methods had higher screening rates than States that did little more than mail notices.[93] In two reports, the Children's Defense Fund described various studies of outreach techniques which indicated that active and sometimes long-term personal contact was necessary if outreach was to be successful. In addition, several studies recommended the use of community residents as outreach workers.[94] In their study of five county EPSDT programs, the Children's Defense Fund reported that "[w]ritten material about EPSDT was seldom read and even less often understood or heeded."[95] The CDF reported further that no parent they interviewed "had been motivated to have her or his child enter the EPSDT program because of a written notice."[96]

In the State of Washington, it was reported that an "active" EPSDT outreach program had been instituted in 1976 with funds available under the Economic Development Act.[97] Outreach workers made the initial contacts, held followup meetings, and provided transportation for EPSDT recipients. The chief of the State's Office of Medical Assistance said that they were trying to locate an alternative source of funding to provide outreach after termination of the EDA grant. Without an outside source of funding, he said, the office would have to eliminate outreach jobs and return to the previous practice of just mailing brochures to AFDC recipients.[98]

The Maine Medicaid program worked with community action programs and other human service agencies to conduct EPSDT outreach. The director of the State's Division of Medical Assistance said that only AFDC recipient children were covered by the outreach efforts.[99]

In addition to mailing a description of EPSDT to AFDC recipients, Mississippi made appointments for eligible individuals and notified each family by mail. The notice included the date, time, and place of the appointment. If an appointment was not kept, the individual was automatically rescheduled.[100] A county in Mississippi was also included in the Children's

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[92] U.S., Department of Health, Education, and Welfare, Health Care Financing Administration, *Delivering EPSDT Services: Outreach and Follow-up in Medicaid's Program of Early and Periodic Screening, Diagnosis and Treatment* (1977) pp. 11–12.

[93] U.S., General Accounting Office, *Improvements Needed to Speed Implementation of Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program*, (1975), p. 9.

[94] Children's Defense Fund, *Doctors and Dollars Are Not Enough*, (Washington Research Project, Inc.: Washington, D.C., 1976), pp. 27–32; and *EPSDT*, pp. 86 and 99–100.

[95] *EPSDT*, p. 88.

[96] Ibid.

[97] 42 U.S.C. §3246b (Supp. V 1975).

[98] Nelson Interview; Haffie Interview.

[99] Fickett Interview.

Defense Fund study of EPSDT. CDF criticized the appointment procedure because it used alphabetical lists of all eligible children and did not relate the frequency of contacts to age. The adolescent was scheduled for a screening as frequently as an infant.[101] CDF also reported that appointments were made without contacting the family to determine if the date, time, and place were convenient or possible to meet. Transportation was provided only if a caseworker reviewed the list of appointments and determined someone needed assistance. In that county, only about 50 percent of the screening appointments were kept.[102]

In Missouri announcements were mailed with AFDC checks once a year. Although more frequently than required by law, the notices may not have produced successful results. One notice simply said, "Does your child have EPSDT?" which State officials thought would heighten interest in the program. Instead many parents thought EPSDT was a disease while others thought it was an immunization. Missouri screened only 7 percent of its eligible children.[103]

Medicaid officials gave several reasons to explain why more screenings were not performed. The most frequent was that parents did not understand the written or oral information presented on EPSDT or preventive care. If a child appeared healthy, it was claimed that a parent was less likely to take him or her to a doctor. The parent waited until the child was sick and there was a "real need" to see the doctor.[104]

The Federal Associate Regional Commissioner for Medical Services in Atlanta reported that throughout the region, "outreach efforts are geared towards the younger age groups."[105] He did not specify what age was younger.

Eligibility Criteria

An issue frequently raised during the field study and public hearings was the absolute lack of Medicaid coverage for many persons in certain age groups. Age affects an individual's eligibility for Medicaid because of both Federal statutory criteria and the eligibility options elected by a State. The age group reported to be affected was persons 21 to 64.

The statute requires a participating State to extend Medicaid coverage to persons receiving benefits under the Federal cash assistance programs. Dr. Peter Fox, Acting Director for Policy Analysis in the Health Care Financing Administration, explained that many Medicaid coverage problems were rooted in the design of the cash assistance programs:

> I think it is important to understand the historical origin of Medicaid. . .Medicaid is an adjunct to a welfare program.

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[100] Ernest Griffins, director, Pediatric Services, Mississippi State Board of Health, interview in Jackson, Miss., May 2, 1977 (hereafter cited as Griffins Interview).

[101] *EPSDT*, p. 96.

[102] *EPSDT*, p. 102.

[103] Morgan Interview; Lange Interview.

[104] Griffins Interview; Singleton Interview;Sossin Interview.

[105] Edward Davis, associate regional commissioner for medical services, interview in Atlanta, Ga., May 5, 1977 (hereafter cited as Davis Interview).

> The whole history of welfare in this country is that one can somehow classify the poor into two categories, the deserving and the undeserving, and therefore, we have certain cash benefits, for example, for unemployed women with children, that we do not make available to men in the same circumstances. But that is built into our welfare system. It is built into our Medicaid system. . .and it is discriminatory.[106]

Age restrictions in SSI and AFDC are reflected by correspondingly low or no Medicaid coverage of certain age groups. To receive SSI under the provisions for being aged, a person must be 65 or older.[107] An individual is otherwise eligible for SSI only if he or she meets the requirements of being blind or disabled.[108] AFDC provides assistance for a dependent child up to age 18 or up to 21, if the child is still in school in some States.[109] A person over 18 or 21 (depending on school attendance) is eligible for AFDC coverage only if *she* (and in some States he) is an eligible caretaker of a dependent child.[110]

A State may include persons other than SSI or AFDC recipients in its Medicaid program. Other eligibility groups, as defined by the statute, include those who would be eligible for cash assistance except for not meeting certain criteria such as not having applied, institutional status, or income level. This does not affect the age restrictions of the SSI or AFDC eligibility criteria, which continue to apply to a State's additional groups of categorically needy and medically needy.[111]

Respondents in six States said that Federal law restricted Medicaid coverage to persons 21 to 64.[112] To be eligible for Medicaid, a low-income person within this age range must have at least one dependent child or be blind or disabled and meet the requirements for cash assistance except, in some States, for income or resource restrictions.

A recent study of Medicaid eligibility noted the general exclusion of persons 21 to 64 and reported that "[i]nterestingly, States accept this categorization of the adult population, given current fiscal constraints."[113]

In two States, disabled SSI recipients under 18 who were ineligible for AFDC were reported to be ineligible for Medicaid on the basis of their SSI status. These States used more restrictive eligibility criteria than SSI, as allowed by Federal law; namely, the criteria that were in effect prior to the SSI program. Under the States' previous assistance program, aid to the permanently and totally disabled had been available only to persons 18 or over. A State must cover disabled individuals under 18 who would be eligible for AFDC if they were not receiving SSI, but does not have to cover those who would not.[114] The Federal Associate Commissioner for Medicaid in Chicago said that some States did not cover disabled persons under 18 because they thought that crippled children's and rehabilitation programs cover "families who are not poor enough to qualify for AFDC."[115] According to the director of assistance payments in Mississippi's Department of Public Welfare, the State did not cover disabled SSI children because "we know there are a good many out there. Since the State Medicaid appropriation is low, covering this group may mean cutting back on services to other children." She said she thought this exclusion from coverage was discrimination on the basis of age.[116]

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[106] Dr. Peter Fox, Acting Director for Policy Analysis, Health Care Financing Administration, testimony, *Washington, D.C. Hearing*, p. 91.

[107] 42 U.S.C. §1382c(a)(1)(A) (Supp. V 1975).

[108] Ibid, and 42 U.S.C. §§1382c(a)(2), (3)(A) (Supp. V 1975).

[109] 42 U.S.C. §§601, 606(a) (1970).

[110] 42 U.S.C. §§601, 606(c) (1970).

[111] 42 U.S.C. §1396d(a) (1970 and Supp. V 1975).

[112] Byron Holliday, director, Mississippi Medicaid Commission, interview in Jackson, Miss., Apr. 28, 1977; Davis Interview; Robert Bavelock, program speicalist, Medical Services Administration, interview in Boston, Mass., May, 1977; Mary Ann Langston, chief of planning, Illinois Bureau of Medical Assistance, interview in Springfield, Ill., May 19, 1977; Dye Interview; Nelson Interview; Dintelmann Interview; Soderberg Testimony, *San Francisco Hearing*, p. 118.

[113] *Comprehensive Review of Medicaid Eligibility*, p. 3-53.

Although these coverage problems for certain age groups arise from the Federal law, some program administrators view the limits as discriminatory. As the representative from Washington State's Office of Medical Assistance indicated, if the State were to provide medical services to persons 21 to 64 who do not meet the categorical requirements, the State would not receive any Federal reimbursement for those services and would have to rely on its own funds.[117] Lack of State funds prevents a State from providing services to persons who do not meet the Federal eligibility categories, since the State must assume the full costs of services. Costs and lack of funds also appear to preclude the inclusion of disabled SSI recipients under age 18 in some State Medicaid programs.

Service Availability

Certain services are provided to some age groups of Medicaid eligibles and not to others. The age limitations on services correspond to the age restrictions on eligibility for the cash assistance programs and are specified in the Federal law or in State plans. The statute places age limits on four services and requires mandatory age coverage for a fifth service:

- Skilled nursing facility service for individuals 21 years of age or older (mandatory service).

- Early and periodic screening, diagnosis, and treatment for those under the age of 21 (mandatory service).

- Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 and over in an institution for tuberculosis or mental diseases.

- Inpatient psychiatric hospital services for individuals under 21.[118]

- Home health care for individuals entitled to skilled nursing facility services

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[114] Frances Evart, director, Assistance Payments Division, Mississippi State Department of Public Welfare, interview in Jackson, Miss., Apr. 27, 1977 (hereafter cited as Evart Interview).

[115] Dye Interview.

[116] Evart Interview.

[117] James M. McCorkill, acting head, Program Administration Section, Washington Office of Medical Assistance, interview in Olympia, Wash., May 3, 1977.

[118] 42 U.S.C. §1396d(a) (1970).

(which must be provided at least for individuals 21 or older.)[119]

A participating State may place limits on the services it will provide under its Medicaid plan, which may be the age limits for particular services; however, a major influence in State-set age limits is the statutory requirement for early and periodic screening, diagnosis, and treatment (EPSDT) for Medicaid eligibles under 21. EPSDT services require that a State provide some services to all eligibles under 21, including medical care, dental services, prescribed drugs, dentures, prosthetic devices, and eyeglasses. A State may provide the services to eligibles 21 or over, but it is not required to do so. Many States, in fact, limit coverage of these "treatment" services to persons under 21.

Robert Derzon stated that, in his view, the major influence on States to restrict Medicaid services has been rising health care costs.[120] Federal and State expenditures for Medicaid have risen from $2.3 billion in 1967 to $14 billion in 1976, and they are estimated to be $19.8 billion in 1978.[121] The Urban Institute has reported that "[t]he Federal share of these expenditures was approximately 53 percent, with State governments contributing 38 percent and local government providing the remaining 9 percent."[122] Dr. Peter Fox of the Health Care Financing Administration explained that ". . .Medicaid is the fastest rising component of State budgets in most States."[123] The increasing cost burden has led to service controls and cutbacks that include age restrictions on services provided.[124]

An Urban Institute study on controlling costs in State Medicaid programs reported that the most frequently used procedure has been the use of limits on both mandatory and optional services and the complete elimination of optional benefits. The report explained that a control or limit placed on a service is "technically, administratively, and politically the easiest cost control to implement."[125] Of course, the limits are not always age specific but include limits on service amounts to be provided or requirements for prior authorization.

One example of a cost control that was given by the chief of the Bureau of Medical Services in Missouri was an age limit. He reported that dental care costs had accounted for 50 percent of the State's Medicaid expenditures in 1970, so in 1972 the State cut back on dental services. The service is now available only to Medicaid eligibles under 21. He claimed that the State eliminated dental care for adults rather than children, because provision of services to children was seen as a preventive measure and because the services were required for children under 21 as part of the EPSDT program.[126]

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[119] 42 U.S.C. §1396a(a)(13)(A)(ii) (Supp. V 1975).

[120] Derzon Testimony, *Washington, D.C. Hearing*, p. 98.

[121] U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Data on the Medicaid Program: Eligibility, Services, Expenditures; Fiscal Years 1966–77* (1977) p. 26. For 1967 payments under the Kerr-Mills program, Medical Assistance for the aged, are included in the total payments reported. Payments were continued under the Kerr-Mills program until 1970 when Federal funds were available to States only for Medicaid.

[122] Holahan, Scalon, and Spitz, *Restructuring Federal Medicaid*, p. 1.

[123] Fox Testimony, *Washington, D.C. Hearing*, p. 99.

[124] Holahan, Scalon, and Spitz, *Restructuring Federal Medicaid*, pp. viii and 4–5. In fact, the study reported that while some States had cutback services based on actual financial strain, other States appeared to have cut back their services "in anticipation of their program expenditures escalating beyond acceptable financial limits."

[125] Ibid., pp. 59–60.

When questioned about States' covering only persons under 21 for some Medicaid services primarily because of EPSDT requirements, Mr. Derzon said:

> . . .as you look at the EPSDT program which is essentially a Medicaid program, there are great gaps in the Medicaid program for the middle-aged Americans, and, as you pointed out quite correctly, there are optional services of a somewhat lesser range for the older people in the Medicaid program than for the young people.[127]

Mr. Derzon later added:

> I think that we would clearly have to say that this [EPSDT] is a discriminatory benefit, that there is a group of Americans receiving a set of benefits at public expense, and there is not another group.[128]

States must account for several factors when designing Medicaid benefit packages under existing statute and Federal regulations, including the current health care cost situation. These factors have combined so that the types of medical services available often vary because of the person's age.

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[126] Singleton Interview.

[127] Derzon Testimony, *Washington, D.C. Hearing*, p. 91.

[128] Ibid.

Chapter 9

Community Health Centers

The community health centers program, authorized under Title III of the Public Health Service Act, as amended,[1] provides primary health and other specified services, to the residents of an area served by a community health center. The act refers to such areas as "catchment areas."[2]

The Commission's review of the program identified several problems related to age discrimination. Its emphasis on preventive health care for young people tends to produce services that are often neither accessible to older persons nor responsive to their needs. Inadequate outreach, or the lack of it, in many instances affects the participation of older persons. Services to young persons were reported to be affected by requirements for parental consent.

Program Description

Community health centers, in the enabling legislation, are defined as entities that provide directly or through contracts or cooperative arrangements with other public or private entities the following services: primary health services; as appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services; referral to supplemental health service providers, including, where appropriate and feasible, payment for providing such services; environmental health services, as appropriate for particular centers; and information on the availability and proper use of health services.[3]

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[1] Pub. L. No. 94-63, 89 Stat. 342 [codified at 42 U.S.C. §254c(Supp. V 1975)].

[2] 42 U.S.C. §254c(a) (Supp. V 1975).

"The existence of medically underserved populations" in an area is also a factor in the establishment or support of community health centers.[4] This term means the population of an urban or rural area designated by the Secretary of Health, Education, and Welfare as an area with a shortage of personal health services or a population group designated as having shortage of such services[5] At least four factors are considered in this designation: (1) available health resources in relation to the size of the area and its population; (2) health indices, such as the infant mortality rate; (3) economic factors affecting the population's access to health services, such as the percentage of the poverty population; and (4) demographic factors affecting the population's need and demand for health services, such as the percentage of the population aged 65 or over.[6]

Primary health services include physicians' services and, where feasible, services of physicians' assistants and nurse clinicians; diagnostic laboratory and radiologic services; preventive health services; emergency medical services; transportation services as required for adequate patient care; and preventive dental services.[7] Supplemental health services are those not included as primary health services and include hospital services, home health services, extended care facility services, rehabilitative services, mental health services, dental services, vision services, allied health services, pharmaceutical services, and public health services.[8]

The current community health centers program embodies a variety of health service delivery models that evolved from the efforts of the former Office of Economic Opportunity (OEO) and the Department of Health, Education, and Welfare (HEW).[9] The oldest model is the neighborhood health center, first initiated by OEO in 1965 when it funded centers in Boston and rural Mississippi.[10] OEO's initiative expanded in 1966 and was formalized in statute with the 1966 amendments to the Economic Opportunity Act.[11] The amendments authorized OEO to develop and implement comprehensive health services programs that focused on the needs of persons in urban or rural areas having high concentrations of poverty and a marked inadequacy of health services for the poor.[12]

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[3] *Id.*

[4] 42 U.S.C. §§254 c(c)(1),(d)(1)(A) and (B) (Supp. V 1975).

[5] 42 U.S.C. §254c(b)(3) (Supp. V 1975).

[6] 41 Fed. Reg. 53,204, 53,206 (1976) (to be codified in 42 C.F.R. §51c.101(e)).

[7] 42 U.S.C. §254c(b)(1) (Supp. V 1975). See also 41 Fed. Reg. 53,205, 53,206 (1976) (to be codified in 42 C.F.R. §51c.101(h)) for the Department of Health, Education, and Welfare's (HEW) further interpretation of the statutory provisions.

[8] 42 U.S.C. §254c(b)(2) (Supp. V 1975). See also 41 Fed. Reg. 53,204, 53,206 (1976) (to be codified in 42 C.F.R. §51c.101(j)) for HEW's further interpretation of the statutory provisions.

[9] U.S., Congress, House, Committee on Interstate and Foreign Commerce, *Health Revenue Sharing and Health Services Act of 1975*, 94th Cong., 1st sess., 1975, H. Rept. 192, pp. 76–80 (hereafter cited as *Health Revenue Sharing Act*).

[10] Elizabeth J. Anderson and others, *The Neighborhood Health Center Program, Its Growth and Problems: An Introduction* (Washington, D.C.: National Association of Neighborhood Health Centers, Inc., 1976), pp. 2 and 12 (hereafter cited as *The Neighborhood Health Center Program*).

[11] 42 U.S.C. §2809(a)(4) (1970 and Supp. V 1975) (repealed 1976).

The Department of Health, Education, and Welfare picked up the OEO model when it received funds to carry out the program authorized by the 1967 amendments to the Public Health Service Act.[13] The neighborhood health centers funded by OEO and HEW were intended to provide a broad package of ambulatory health services to medically underserved populations and to coordinate Federal, State, and local resources into a comprehensive health care program.[14]

While the neighborhood health center flourished as a method for delivering health care in urban areas, the "family health center" model was developed in response to the needs of persons in rural areas.[15] These rural centers were designed to provide a prescribed set of ambulatory health services to families enrolled on a prepaid health care plan basis.[16] The prepaid plan approach to health care in urban areas began with OEO's initiation of the "community health network" to provide poor persons access to a coordinated package of services through a prepaid capitation plan.[17]

By 1974, authority for the community health services program was vested in HEW.[18] In 1975 HEW initiated a fourth program model—the rural health initiative—as a cooperative effort among a variety of health programs, including community health centers, migrant health services, and the national health service corps program, to increase primary health care delivery in medically underserved rural areas.[19] In 1976 HEW added the most recent approach in its urban health initiative designed to integrate the resources of community health centers, national health service corps, maternal and child health, and family planning to form an urban health system.[20]

The Health Revenue Sharing and Health Resources Act of 1975 amended the Public Health Service Act to provide for the current community health centers program.[21] The act authorizes three different kinds of grants: (1) grants to public and nonprofit private entities to plan and develop community health centers which will serve medically underserved populations;[22] (2) grants to public and nonprofit private community health centers serving medically underserved populations to meet their operating costs;[23] and (3) grants to public and private nonprofit entities that provide health services to medically underserved populations but do not meet all of the requirements or specifications for community health centers.[24]

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[12] *Id.*

[13] 42 U.S.C. §246 (1970) (repealed 1975). See also *Health Revenue Sharing Act*, p. 77.

[14] 42 U.S.C. §2809(a)(4) (1970 and Supp. V 1975) (repealed 1976), 42 U.S.C. §246 (1970) (repealed 1975). For discussion see *Health Revenue Sharing Act*, p. 78.

[15] *Health Revenue Sharing Act*, p. 79.

[16] Ibid.

[17] Ibid., p. 80.

[18] Ibid., pp. 79–80.

[19] U.S., Department of Health, Education, and Welfare, Health Services Administration, *Forward Plan for FY 1978–82* (1976), p. 79, and U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services Administration, *Rural Health Initiative* (1976), pp. 1-4.

[20] U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services Administration, Bureau of Community Health Services, *Integrated Urban Health Guidance* (1977), Introduction, pp. 1–3, and *Integrated Urban Health Strategy*, pp. 1–3.

[21] 42 U.S.C. §254c (Supp. V 1975).

[22] 42 U.S.C. §254c(c)(1) (Supp. V 1975). No more than two of this kind of grant may be made for the same project §254c(c)(2).

The community health centers program is administered by the Bureau of Community Health Services within the Health Services Administration, Public Health Services, Department of Health, Education, and Welfare. Central office responsibilities include policy development and interpretation, allocation of funds to the Federal regional offices for award to programs, and data collection and maintenance. The HEW regional offices administer the program on a day-to-day basis, provide technical assistance to programs, and approve grant applications.[25]

Commission staff visited 13 community health centers as part of the field study and in connection with the public hearings. They are listed as appendix A.

Summary of the Record

Program Participants

Sufficient data were not available either nationally or by catchment areas to afford meaningful comparisons between the ages of participants in the community health centers program and the ages of the eligible population. Because community health centers do not cover the entire country and because age data were not available for either the general population or the low-income population within each center's catchment area, Commission staff were unable to establish an eligible population profile. Table 9.1 displays calendar year 1976 program participants data that were made available to Commission staff during the study.

Data on health needs by age group are difficult to obtain. It has been reported that persons "65 and older have more health care problems, higher rates of chronic illness, and per capita medical care expenditures three times those of persons between 19 and 64."[26] Dr. Robert Butler, in his book *Why Survive? Being Old in America,* wrote that the "average annual medical bill for persons 65 and older in fiscal 1972 was $982, compared to $147 for youth under 19 and $358 for those 19 to 65."[27] Dr. Butler also noted that older persons incur 25 percent of all health expenses, although they represent 10 percent of the population.[28] Older persons also incur greater drug costs than younger

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[23] 42 U.S.C. §254c(d)(1)(A) (Supp. V 1975).

[24] 42 U.S.C. §254c(d)(1)(B) (Supp. V 1975).

[25] Siegel Young, acting deputy director, Program Office for Community Health Centers, Bureau of Community Health Services, interview in Rockville, Md., Jan. 5, 1977.

[26] U.S., Congress, Senate, Subcommittee on Aging, Committee on Labor and Public Welfare, *Hearings: Legislation to Extend the Older Americans Act of 1975, S. 1425 and H.R. 3922,* 94th Cong., 1st sess., 1975, Arthur S. Flemming, U.S. Commissioner on Aging, testimony, p. 390.

[27] Robert N. Butler, M.D., *Why Survive ? Being Old in America* (New York: Harper and Row, 1975), p. 207 citing "Medical Care, Spending for Three Age Groups" *Social Security Bulletin,* 1972.

[28] Ibid. Dr. Butler notes that health expenses and medical expenses are not the same; the former are greater because they include out-of-pocket uninsured costs.

Table 9.1

Percent Distribution of Community Health Center Users by Age, Calendar Year 1976

Age Groups	Users
All Ages	100.0%
less than 1	4.1
1 - 4	11.1
5 - 12	16.1
13 - 44	47.5
45 - 64	13.5
65+	7.8

Source: U.S., Department of Health, Education, and Welfare, Public Health Service, Health Services Administration, Bureau of Community Health Services, letter to Commission Staff, Oct. 17, 1977.

persons, accounting for 25 percent of all drugs prescribed.[29]

Even if their needs for health services were conservatively estimated to be no greater than that of the entire population, on a nationwide basis it could be anticipated that older persons would have a 10 percent participation rate, based on their representation in the population.[30] Because the community health centers program grew out of the Federal Government's anti-poverty efforts and has maintained a concern for health services to the poor, it might also be expected that nationwide there would be a 13.3 percent participation rate for older persons, based on their representation in the poverty population.[31] The lack of data for catchment area populations and for medically underserved populations within catchment areas restricts analysis.

Despite limited age data, the community health services program has been described as serving primarily children and women. According to the report of a HEW-sponsored study, as of the last quarter of 1973 the majority of the patients utilizing the services of a neighborhood health center were children between the ages of 5 and 14 and women of childbearing age (15–44). Approximately

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[29] Ibid., p. 149.

[30] U.S., Department of Commerce, Bureau of the Census, *USA—Statistics in Brief, 1976: A Statistical Abstract Supplement.*

[31] U.S., Department of Commerce, Bureau of the Census, *Money Income and Poverty Status of Families and Persons in the United States: 1976* (Advance Report) (1977), Series P–60, No. 107, p. 20.

12 percent of the patients were between 45 and 64; 6 percent were 65 and over.[32] (As described earlier, the neighborhood health center was one health care model supported under the community health centers program.)

For fiscal years 1974 and 1975, the Bureau of Community Health Services reported that persons aged 65 or over made up an estimated 6 percent of center registrants.[33] With respect to the percentage distribution of other age groups, HEW reported that for the period from January through March 1975, 2 percent of the participants were under age 1, 13 percent were aged 1 to 4, 23 percent were aged 5 to 14, 44 percent were aged 15 to 44, and 12 percent were aged 45 to 64.[34] The Federal program consultant for community health centers in New York said that the program emphasizes services to youth and women of childbearing age. He cited Public Health Service priorities such as immunization of children, birth control, treatment of venereal disease among teenagers, and obstetric care for women as accounting, in part, for the program's direction.[35] Other administrators, although not endorsing the belief that older persons are excluded from participation, also agreed that there is an overall emphasis on maternal and child health services in the program as reflected in the Health Services Administration's *Forward Plan for Fiscal Years 1978–82.* [36] The *Forward Plan* priorities may in turn reflect language in the act. In defining primary health services, the act includes: "preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, prenatal services, well child services, and family planning services)."[37] Such language, however, does not restrict preventive health services to the kinds enumerated or establish a priority for such services. Even where services were included that could have been interpreted as being for the general population in need, it appears that such services were considered to be for narrower age groups. For example, primary health services are defined as including "preventive dental services" and no age-based examples are given; however, as will be shown, dental services that were offered were generally limited to the younger age groups.

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[32] Anderson, *The Neighborhood Health Center Program*, p. 2 citing U.S., Department of Health, Education, and Welfare, Bureau of Community Health Services, *Comprehensive Health Services Projects Data Base Report: Fourth Quarter 1973).*

[33] U.S., Congress, Senate, Special Committee on Aging, *Developments in Aging: 1974 and January—April 1975*, 94th Cong., 1st sess., 1975, S. Rept. 250, p. 222; U.S., Congress, Senate, Special Committee on Aging, *Developments in Aging: 1975 and January-May 1976*, 94th Cong., 2d sess., 1976, S. Rept. 988, p. 116.

[34] U.S., Department of Health, Education, and Welfare, Health Services Administration, Bureau of Community Health Services, Division of Monitoring and Analysis, *Neighborhood Health Centers, Summary of Project Data: Report 10, First Quarter 1975* (1975), p. 18. The data are based on 76 of the 105 centers that were in operation at that time. p. 2.

[35] Barry Gordon, regional program consultant for community health centers, interview in New York, N.Y., Feb. 11, 1977 (hereafter cited as Gordon Interview).

[36] Dr. George Reich, Regional Health Administrator, U.S. Public Health Service, interview in Atlanta, Ga., May 2, 1977 (hereafter cited as Reich Interview); Dr. Aaron Shirley, project director, Jackson-Hinds Comprehensive Health Center, interview in Jackson, Miss., Apr. 26, 1977 (hereafter cited as Shirley Interview); Douglas Woods, acting chief, Community Health Branch, Division of Health Services, U.S. Public Health Service, interview in Seattle, Wash., May 5, 1977 (hereafter cited as Woods Interview); Mark Williams, assistant director for finance, Mile Square Health Center, interview in Chicago, Ill., May 16, 1977 (hereafter cited as Williams Interview); Louis Hines, regional program consultant for the community health centers program, U.S. Public Health Service, interview in Dallas, Tex., May 3, 1977 (hereafter cited as Hines Interview); and Gordon Interview; Dr. Sheridan Weinstein, Regional Health Administrator, U.S. Public Health Service, testimony, *Hearing Before the U.S. Commission on Civil Rights, San Francisco, California*, June 27–28, 1977, vol. I, p. 36 (hereafter cited as *San Francisco Hearing).*

[37] 42 U.S.C. §254(c)(b)(1)(C)(Supp. V 1975).

Two centers operating under prepaid plan models established eligibility rules which excluded those persons receiving or eligible to receive assistance under Medicare or Medicaid.[38] These rules were based on their efforts to enroll persons who were not covered by any health insurance plans. Although exclusion of Medicaid eligibles or recipients affects a wide age range of individuals, exclusion based on Medicare status virtually rules out participation by most older persons. Because Medicare places severe restrictions on reimbursement for outpatient services,[39] such policies may result in preventing older persons from obtaining the outpatient treatment they need, particularly when community health centers are, by definition, located in areas with limited health facilities.

The center in San Antonio established an eligibility requirement that excluded from participation in its program persons under the care of either a private physician or a faculty member of the university medical school with which the center is associated.[40] The Federal program consultant for the community health centers program in Dallas indicated that this requirement may result in lower utilization of center services by older persons than other age groups because of their greater tendency to have physician contact in connection with Medicare. He added that because of this requirement, older persons also lose out on drug services provided by centers.[41]

One center director said that in his experience those who fall within the middle-aged group are overlooked in the provision of community health services.[42] This point was also made by a Federal official who said that most of the community health centers in the Boston region deal primarily with pediatric and geriatric services, while the middle-aged groups are not served as often. He said that he saw the programs in his region being directed primarily toward the very young, women of childbearing age, and the very old. He also said that women of childbearing age and mothers seeking services on behalf of their children account for the largest volume of services, with older persons following but in terms of frequency of use not numbers of participants.[43] The director of another center said that a high proportion of females and children are served in his program.[44]

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[38] Margaret Foberg, assistant director, Penobscot Bay Medical Center Ambulatory Care Program, interview in Rockland, Me., May 23, 1977 (hereafter cited as Foberg Interview); William Drucker, director, Community Health Board of Seattle, interview in Seattle, Wash., April 27, 1977 (hereafter cited as Drucker Interview). Commission staff followed up by telephone several months after the site visits to verify the existence of the stated policies. It was learned that the Community Health Board of Seattle had eliminated such policies in January 1977 contrary to information obtained in the May interview. The Maine center had not changed its policies.

[39] 42 U.S.C. §§1395f-g (1970 and Supp. V 1975).

[40] San Antonio, Tex., Application for Federal community health center funds, Comprehensive Family Health Care Delivery Model (1976), attachment 2.

[41] Hines Interview.

[42] Robert Smith, director, Martin Luther King Neighborhood Health Center, interview in Chicago, Ill., May 16, 1977 (hereafter cited as Smith Interview).

Armando Atencio, deputy manager of the Denver Department of Health and Hospitals, testified that within the public health system for the city and county of Denver, which includes the neighborhood health centers, the percentage of younger persons using available health services is greater than their proportionate number in the population. He added that older persons represent a lower percentage of users compared to their numbers in the population.[45]

Dean Hungerford, Director of the Division of Health Services for the U.S. Public Health Service in Denver, told the Commission that, based on data on community health centers funded in the region, a greater population of children are served by the centers in relation to their proportion of the general population than are those aged 65 or over.[46]

Charles Range, executive director, Drew Medical-Dental Center in East Palo Alto, California, testified that his center basically serves youth and individuals between the ages of 25 and 45. He indicated further that although older persons make up a relatively low proportion of the population, the center serves fewer older persons than their proportionate representation.[47]

The director of the Northeast Medical Center in San Francisco testified that a unique situation existed at her center in terms of the age distribution of the participants, since older persons exceed their proportion of the target area's general population. A similar situation exists insofar as persons from birth to 15 are concerned: 25 percent of the center's participant population falls within this age group, whereas they account for 14 percent of the target area's general population.[48]

Preventive Health Care Policies

Preventive health services oriented toward women of childbearing age, children, and youth is one age-related priority evident in the program. The Public Health Service's *Forward Plan for Fiscal Years 1978–82* includes, as a major theme, the development and expansion of preventive health services. The plan devotes nearly all of its discussion of preventive health to the needs of children, youth, and young adults.[49]

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[43] Ken Brown, regional program consultant for the community health centers program, interview in Boston, Mass., May 27, 1977 (hereafter cited as Brown Interview).

[44] Robert Whitmore, project administrator, Comprehensive Family Health Care Delivery Model interview in San Antonio, Tex., Apr. 27, 1977 (hereafter cited as Whitmore Interview).

[45] Armando Atencio, testimony, *Hearing Before the U.S. Commission on Civil Rights, Denver, Colorado*, July 28–29, 1977, vol. I, p. 29 (hereafter cited as *Denver Hearing).*

[46] Dean Hungerford, testimony, *Denver Hearing*, p. 30.

[47] Charles Range, testimony, *San Francisco Hearing*, p. 148.

[48] Sophie Wong, testimony, *San Francisco Hearing*, pp. 149–50.

[49] U.S., Department of Health, Education, and Welfare, Public Health Service, *Forward Plan for*

Health center officials and Federal regional administrators indicated that the centers appear to have assumed the Public Health Service priorities and are targeting preventive care efforts on the younger population.[50] Dr. Sheridan Weinstein, Regional Health Administrator for the U.S. Public Health Service in San Francisco, testified:

> I believe that our emphasis on prevention has in good measure been targeted at the younger age groups. It has been targeted to children. It's been targeted at mothers. And it's both in the medical area as well as in the dental area. It does not represent any exclusion of services in the elderly. . .or middle aged; it is just our belief that the payoff is a little better the younger you have intervention, vis-a-vis preventive activities.[51]

Armando Atencio, deputy manager of the Denver Department of Health and Hospitals, suggested that there was a relationship between his agency's emphasis on preventive health care and the higher utilization of health services by youth. "It's possible," he said, "that because we emphasize or place a great deal of emphasis on the young people in the prevention area that the elderly are being left out."[52]

Dean Hungerford, after informing the Commission that older persons were underrepresented in the centers in the Denver region, indicated that the preventive health care emphasis was a policy that would tend to produce such results.

> I believe that the nature of the program itself and probably some emphasis that is given to preventive services, immunizations, services to mothers and children would result in this without there being frank or overt discrimination. I think the nature of the services that are provided would result in this disproportionate number of children that are seen as compared to the over 65.
>
> Our guidance for the work plan next year does emphasize child health programs. This is not to say that dollars for the support of services to the population generally are being diverted to that activity. But, again, with the emphasis, I think that there is a tendency then for more emphasis to be given in the centers to that sort of service.[53]

The field study showed that several centers restricted or limited dental services entirely to youth.[54] The reasons offered for these policies can best be summarized by the following paraphrase: "The great-

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FY 1978–82 (1976), pp. 69–83. The same prevention theme and concentration of its treatment on children and youth is found in the Health Services Administration (HSA) Forward Plan for fiscal years 1978–82. HSA is the component agency of the Public Health Service that is responsible for the community health centers program.

[50] Reich Interview; Woods Interview; Hines Interview; Gordon Interview; Williams Interview; Shirley Interview; Smith Interview; Drucker Interview.

[51] Dr. Weinstein Testimony, *San Francisco Hearing*, p. 136.

[52] Atencio Testimony, *Denver Hearing*, p. 29.

[53] Hungerford Testimony, *Denver Hearing*, pp. 30–31.

[54] Shirley Interview; Drucker Interview; Foberg Interview; A. J. Henley, director, Yeatman Health Center, interview in St. Louis, Mo., Apr. 6, 1977 (hereafter cited as Henley Interview).

est amount of good can be done by preventing dental disease at an early age rather than more costly treatment for older people with years of dental neglect."[55] One Federal regional official put it in more concrete terms: "$10 of service for a child may be worth $1,000 over a lifetime and $10,000 for an older person may not be worth anything at all."[56] In fact, the same reasoning was advanced to justify focusing preventive health care efforts in general on young people.[57]

Dr. Julius Richmond, Assistant Secretary for Health of the Department of Health, Education, and Welfare, confirmed in his written response to questions submitted by the Commission that the intent of preventive health care is to result in a services focus on children, youth, and women of childbearing age.[58] He said, "It is expected that such preventive services will help to reduce the numbers and kinds of health problems that future generations of aged persons will have."[59]

Interpretation of preventive health services as being necessary and applicable for persons of all ages was expressed by only one official interviewed by Commission staff. He indicated that the preventive health thrust should be expanded to include testing for hypertension, diabetes, high cholesterol levels, and other diseases affecting primarily adults.[60] Assistant Secretary Richmond did indicate that his agency is expanding its efforts into this area by implementation of a recently enacted program under section 314(d) (7) (B) of the Public Health Service Act that involves screening, detection, diagnosis, prevention, and referral for hypertension.[61]

Parental Consent Requirements

Leonard Fitchenbaum, director of planning and education for the Yeatman Health Center in St. Louis, cited Missouri's parental consent laws as a factor impeding the delivery of health services to youth. According to Mr. Fitchenbaum, an unemancipated youth must be 21 years of age or be accompanied by a parent or guardian to receive services.[62]

Mark Williams, assistant director for finance for the Mile Square Health Center in Chicago also cited parental consent requirements as a deterrent to serving youth. He indicated that except for venereal disease and family planning, an unemancipated youth must be 18 years of age or have the consent of a parent or guardian to receive services in Illinois.[63] Robert Smith, director of the Martin Luther King Neighborhood Health Center in Chicago, also cited the State's parental consent rules to explain problems in serving youth.[64]

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[55] Ibid.

[56] Hines Interview.

[57] Woods Interview; Henley Interview; Hines Interview; Gordon Interview.

[58] Dr. Julius Richmond, letter to Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights, Oct. 18, 1977 (hereafter cited as Richmond Letter).

[59] Ibid.

[60] Brown Interview.

[61] Richmond Letter.

[62] Fitchenbaum Interview. See also the discussion of parental consent requirements in the chapter entitled "Community Mental Health Centers."

[63] Williams Interview.

[64] Smith Interview.

Outreach Activities

Outreach services are optional under the community health centers program and are intended to promote and facilitate the use of primary and other health services.[65]

Most centers covered in the Commission's field study had at one time provided some form of outreach services; however, several center officials stated in interviews and during the public hearings that because of an emphasis on financial viability in their centers, they had eliminated outreach.[66] Given a choice between providing direct health services and outreach, the decision was generally made to provide services.[67]

Dr. Abel Ossorio, Deputy Health Administrator for the U.S. Public Health Service in Denver, testified:

> Most of the community health centers right now are under tremendous pressure as a matter of national policy to contain costs and to become economically viable. . . .Under these circumstances an outreach program, the hiring of people who will make contacts with the aged in the homes, as is necessary in many cases, becomes an overhead cost which the community health center feels it cannot support under the existing economic constraints. . . .[38]

Several other Federal officials stated that they discouraged community health centers in their regions from providing outreach.[69] One of these administrators explained that if he had to choose between two projects to receive Federal funds, one with outreach and the other without, he would favor the latter.[70] Another administrator said that whenever budget reductions occur, outreach is the first item to be reduced.[71]

Centers that had reduced or eliminated their outreach efforts or had never instituted such efforts relied on "word-of-mouth" to inform the community that their services were available, or on referrals from other agencies, or on the distribution of pamphlets or other literature.[72] Officials of these centers believed that all members of their communities were aware of the center's services, but they could provide nothing to support this contention.[73]

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[65] 41 Fed. Reg. 53,204, 53,206 (1976) (to be codified in 42 C.F.R. §51c.102(j)(14)).

[66] Foberg Interview; Drucker Interview; Williams Interview; Shirley Interview; Wade Kirstein, regional program consultant for community health centers, U.S. Public Health Service, interview in Kansas City, Mo., Apr. 11, 1977 (hereafter cited as Kirstein Interview); Atencio testimony, *Denver Hearing*, p. 36; Dr. Abel Ossorio, Deputy Regional Health Administrator, U.S. Public Health Service, testimony, *Denver Hearing*, pp. 32, 37.

[67] Foberg Interview; Drucker Interview; Williams Interview; Shirley Interview; Kirstein Interview; Atencio Testimony, *Denver Hearing*, p. 40; Dr. Donald Fink, executive director, San Francisco Medical Center Outpatient Improvement Programs, testimony, *San Francisco Hearing*, p. 151.

[68] Dr. Ossorio Testimony, *Denver Hearing*, p. 32.

[69] Gordon Interview; Jim Tye, regional program consultant for community health centers, U.S. Public Health Service, interview in Chicago, Ill., May 20, 1977 (hereafter cited as Tye Interview); Kirstein Interview.

[70] Kirstein Interview.

[71] Gordon Interview.

[72] Whitemore Interview; Williams Interview; Foberg Interview; Henley Interview; Shirley Interview.

[73] Ibid.

The relationship between the need for outreach directed to older persons and their participation in the program was underlined in the public hearings. Asked whether an outreach program serving as a bridge between older persons and the services available was necessary to remedy problems of underutilization by this age group, Dr. Abel Ossorio agreed, although he expressed reservations about where such responsibility should be placed.[74] Charles Range, executive director of the Drew Medical-Dental Center, East Palo Alto, cited the lack of outreach services as one of three factors contributing to the low utilization of services by older persons.[75] Sophie Wong, director of the Northeast Medical Center in San Francisco, attributed, in part, the high participation levels of older persons in her program to its outreach and transportation efforts.[76]

Addendum

Prior to publication of part II of the age discrimination report, Commission staff received a letter from the Assistant Surgeon General in respect to the Commission's findings of age discrimination related to the community health centers program. The text of the letter follows:

In relationship to last year's hearing with respect to age discrimination, and to subsequent analysis of information, there were suggestions that Community Health Centers discriminated against aged patients. Such conclusions were drawn when information on patients served indicated that Community Health Center users, age 65 or over, constituted a smaller proportion of the user population than the proportion of aged citizens to the general population. It was noted that, nationally, the Community Health Centers' aged user group amounted to about 8 percent of all those served. This percentage was compared with information that 10.7 percent of the U.S. population is age 65 and over.

Several items of information were not considered or available at that time which we would like to make part of the record.

. . .It is inappropriate to equate Community Health Centers' service populations with the general population. Community Health Centers serve people in the following racial proportions: Black, 84 percent; Spanish, 3 percent; Other, 3 percent; White, 9 percent.

Of the Nation's black population only 7.6 percent are 65 and over—compared with 10.7 percent of the general population in that category. Information from our 1977 reporting system indicated that in our Rural Community Health Centers, 9.5 percent of users are 65+. In Urban Centers, 6.9 percent are 65 and over. Altogether, Community Health Centers served 189,000 aged patients or 7.6 percent of the total user population. Because the preponderance of that population is black it seems more appropriate to compare that 7.6 percent with the percentage of aged in the black population; i.e., 7.6 percent rather than with the 10.7 percent of aged in the general population

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[74] Dr. Ossorio Testimony, *Denver Hearing*, pp. 33–34.

[75] Range Testimony, *San Francisco Hearing*, p. 148.

[76] Wong Testimony, *San Francisco Hearing*, p. 149.

In our opinion, therefore, there is no overall indication of failure to reach the aged through the Community Health Center program. There may be, of course, individual centers which have not given sufficient attention to outreach activities, but that could not be ascertained except on a center-by-center basis. Irrespective of individual projects' records in reaching older people, we are making positive efforts to enhance the quality of our health of the aged programming. We are devising regional educational activities for center personnel with respect to care of the aged. We are continuing our efforts to develop cooperative projects with the Administration on Aging and, otherwise, we are emphasizing to regional staff our concern for health problems of particular importance to older people.

We hope it is useful for you to have this additional information. Our best wishes for your continuing endeavors. (Edward D. Martin, M.D., Assistant Surgeon General and Director, Health Services Administration, Public Health Service, Department of Health, Education, and Welfare)

Community Mental Health Centers

APPENDIX A

Site	Local Project(s) Visited
	Field Study
Chicago, Illinois	Ravenswood Hospital Medical Center Edgewater-Uptown Community Mental Health Center
Seattle, Washington	Highline-West Seattle Community Mental Health Center
Jackson, Mississippi	Jackson Mental Health Center
State of Maine	Kennebec Valley Mental Health Center
San Antonio, Texas	Bexar County Mental Retardation/ Mental Health Center, Southeast Bexar County Mental Retardation/ Mental Health Center, Southwest
Kansas City, Missouri	Tri-County Community Mental Health Center
	Public Hearings
San Francisco, California	Westside Community Mental Health Center Bayview/Southeast Community Mental Health Center
Denver, Colorado	Northwest Denver Community Mental Health Center Park East Community Mental Health Center
Miami, Florida	Jackson Memorial Hospital Community Mental Health Center

Legal Services Projects

APPENDIX B

Site	Local Project(s) Visited
	Field Study
Chicago, Illinois	Cook County Legal Assistance Foundation, Inc. Legal Assistance Foundation of Chicago
Seattle, Washington	Evergreen Legal Services
Jackson, Mississippi	Central Mississippi Legal Services
State of Maine	Pine Tree Legal Assistance, Inc.
San Antonio, Texas	Bexar County Legal Aid Association
St. Louis, Missouri	Legal Aid Society of the City and County of St. Louis
	Public Hearings
San Francisco, California	San Francisco Neighborhood Legal Assistance Foundation Youth Law Center Legal Aid Society of San Mateo County California Rural Legal Assistance
Denver, Colorado	Legal Aid Society of Metropolitan Denver Colorado Rural Legal Services, Inc.
Miami, Florida	Legal Services of Greater Miami, Inc.

Appendix C

A total of 52 institutions were visited by Commission staff. The following are those institutions.

COMMUNITY JUNIOR COLLEGES

City College of San Francisco

Community College of Denver

Prince George's Community College—Maryland

Dundalk Community College—Maryland

Community College of Baltimore—Maryland

Community College of Philadelphia

Peirce Junior College—Philadelphia

Miami-Dade Community College—Miami

Montgomery College—Maryland

FOUR-YEAR INSTITUTIONS

Simpson College—San Francisco

Metropolitan State College—Denver

Loretto Heights College—Denver

Regis College—Denver

St. Johns College—Maryland

St. Mary's College—Maryland

Philadelphia College of Textile and Sciences

Swarthmore College—Philadelphia

Mary Washington College—Virginia

Randolph-Macon College—Virginia

University of the District of Columbia

Washington Technical Institute—Washington, D.C.

College of Boca Raton—Florida

UNIVERSITIES

Masters Level Program

Morgan State University—Maryland

Bowie State College—Maryland

Coppin State College—Maryland

George Mason University—Virginia

Doctoral Level Programs

University of California at Berkeley

Stanford University—Palo Alto, California

University of San Francisco

University of Colorado—Denver

University of Colorado—Boulder

University of Denver

University of Maryland—College Park

University of Baltimore—Maryland

Johns Hopkins University—Maryland

Temple University—Philadelphia

Drexel University—Philadelphia

University of Pennsylvania

Virginia Commonwealth University

College of William and Mary—Virginia

American University—Washington, D.C.

Catholic University—Washington, D.C.

Georgetown University—Washington, D.C.

George Washington University—Washington, D.C.

Howard University—Washington, D.C.

University of Miami

Florida Atlantic University

University of Maryland at Baltimore

Schools of Social Work

Stanford University

University of San Francisco

Florida Atlantic University

Catholic University

Howard University

University of Maryland

University of Pennsylvania

Virginia Commonwealth University

University of Denver

SCHOOLS OF DENTISTRY

University of California—San Francisco Medical Center

Georgetown University

Howard University

University of Maryland

University of Pennsylvania

Temple University

University of Colorado Medical Center

Virginia Commonwealth University

LAW SCHOOLS

University of California at Berkeley

Stanford University

University of San Francisco

University of Miami

American University

Catholic University

Georgetown University

George Washington University

Howard University

University of Maryland

University of Baltimore

Temple University

College of William and Mary

University of Denver

University of Colorado at Boulder

MEDICAL SCHOOLS

University of Pennsylvania

George Washington University

Temple University

Hahnemann Medical College

Medical College at Pennsylvania

Georgetown University

University of Maryland

Johns Hopkins University

Virginia Commonwealth University

Stanford University

University of California—San Francisco Medical Center

University of Miami

Howard University

University of Colorado Medical Center

University of Florida

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